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March 29, 2022
Report 2021-123
FACT SHEET

Michael S. Tilden, CPA *Acting State Auditor*

CONTACT: *Public Affairs Office* | *(916) 445-0255*

California Hospice Licensure and Oversight

The State's Weak Oversight of Hospice Agencies Has Created Opportunities for Large-Scale Fraud and Abuse

Background

Hospice agencies provide palliative and end-of-life care for terminally ill patients, and they may provide this care in a patient's home or in other appropriate settings. As of January 2022, there were more than 2,800 hospice agencies licensed to operate in California. The California Department of Public Health (Public Health) is responsible for licensing hospice agencies and for investigating complaints. Other federal and state entities, such as the California Department of Health Care Services (Health Care Services), oversee other components of hospice care. In 2020 Medicare paid more than $3 billion for hospice services provided to 162,000 patients in California, but the State also pays for these services through Medi Cal, the Medicaid program administered by Health Care Services, which generally serves low income individuals.

Key Findings

- Numerous indicators suggest large-scale hospice fraud and abuse is likely occuring in Los Angeles County:
  - » A rapid increase in the number of hospice agencies with no clear correlation to increased need.
  - » Excessive geographic clustering of hospices with sometimes dozens of separately licensed agencies located in the same building.
  - » Unusually long durations of hospice services provided to individual patients.
  - » Abnormally high rates of still-living patients discharged from hospice care.
  - » Hospice agencies using possibly stolen identities of medical personnel.
- Public Health has failed to provide the level of oversight necessary to prevent fraud and abuse by hospice agencies.
- State agencies have not adequately coordinated their fraud prevention efforts or developed meaningful enforcement measures.

Key Recommendations

The Legislature should require Public Health, Health Care Services, the California Department of Justice (DOJ), and the Department of Social Services to immediately convene a taskforce to identify, investigate, and prosecute fraud and abuse by hospice agencies in Los Angeles County.

The Legislature should maintain the general moratorium on new hospice licenses until Public Health issues emergency regulations to, among other things, establish patient-to-staff ratios, enhance inspections and compliance verification, and institute experience requirements for hospices agencies key management personnel.

The Legislature should revise state law to require that new hospice agencies demonstrate an unmet need for their services in the area they wish to operate, and it should ensure that the number of hospice agencies in a given geographic region closely aligns with established measures of the need for such services.

DOJ should ensure that Public Health provides it with the information it needs to fully investigate referred complaints of possible fraud and abuse.

Federal and State Entities Have Identified Various Indicators of Hospice-Related Fraud and Abuse

Proliferation of New Providers | Clusters of Providers | Stolen Identities | Long Lengths of Service | High Live Discharge Rates

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CALIFORNIA STATE AUDITOR
621 Capitol Mall, Suite 1200 | Sacramento | CA | 95814

916.445.0255 | TTY **916.445.0033**

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March 29, 2022
2021-123

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As directed by the Joint Legislative Audit Committee, my office conducted an audit of the State's licensure and oversight of hospice agencies and found that the State's weak controls have created the opportunity for large-scale fraud and abuse. We identified numerous indicators of such fraud and abuse by hospice agencies, which typically offer palliative end-of-life care to individuals with medical diagnoses of fewer than six months to live. The fraud indicators we found particularly in Los Angeles County include the following:

- A rapid increase in the number of hospice agencies with no clear correlation to increased need.
- Excessive geographic clustering of hospices with sometimes dozens of separately licensed agencies located in the same building.
- Unusually long durations of hospice services provided to individual patients.
- Abnormally high rates of still-living patients discharged from hospice care.
- Hospice agencies using possibly stolen identities of medical personnel.

These indicators strongly suggest that a network or networks of individual perpetrators in Los Angeles County are engaging in a large and organized effort to defraud the Medicare and Medi-Cal hospice programs. Such fraud places at risk the extremely vulnerable population of hospice patients.

The California Department of Public Health's (Public Health) inadequate performance of its licensing and investigative functions has enabled this suspected fraud. Without regulations to guide its oversight, its initial licensing site visits and ongoing monitoring do not adequately safeguard patient care or prevent fraud. Its investigation of complaints involving hospice agencies is often incomplete and slow, which increases the risk that patients may receive substandard care or that hospice agencies may engage in fraudulent activity. Public Health has not sought statutory enforcement measures to address problems that it identifies through its oversight, and Public Health and the California Department of Health Care Services do not coordinate with each other to comprehensively assess fraud risks.

Respectfully submitted,

MICHAEL S. TILDEN, CPA
Acting California State Auditor

Selected Abbreviations Used in This Report

Cal Health Find	California Health Facility Information Database
CMS	Centers for Medicare and Medicaid Services
DOJ	California Department of Justice
MedPAC	Medicare Payment Advisory Commission
OIG	Office of the Inspector General of the U.S. Department of Health and Human Services

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Summary

Results in Brief

In the past 10 years, growth in the number of hospice agencies in Los Angeles County has vastly outpaced the need for hospice services. Hospice agencies provide end-of-life care for individuals who are terminally ill—patients who are extremely vulnerable and heavily reliant on caregivers. Although the majority of hospice services were provided by nonprofit organizations in the past, this recent wave of growth is almost exclusively in for-profit companies. Further, numerous indicators suggest that many of these hospice agencies may have been created to fraudulently bill Medicare and Medi-Cal for services rendered to ineligible patients or services not provided at all. This type of fraud can be lucrative. For example, a hospice agency that bills for 20 patients at the most common rate can collect about $122,000 per month. Nonetheless, the state agencies responsible for overseeing hospice care in California have failed to take adequate measures to prevent such fraud or to protect patients from unqualified and unscrupulous providers.

The prevalence and number of fraud indicators in Los Angeles County suggest a large-scale, targeted effort to defraud Medicare and Medi-Cal. For example, we identified several areas within Los Angeles County with extremely high concentrations of hospice agencies, including individual buildings supposedly housing dozens of hospice agencies. In fact, the California Department of Public Health (Public Health) reported a single building in the community of Van Nuys as having more than 150 licensed hospice and home health agencies—a number that exceeds the structure's apparent physical capacity. Further, in 2019 Los Angeles County had more than six times the national average number of hospice agencies relative to its aged population. Consequently, each hospice agency in the county had an estimated average of fewer than five patients per day, as opposed to the average for the rest of the State of 56 patients per hospice agency per day.

Because of the interrelationship between fraud and patient abuse, the prevalence of fraud indicators raises significant concerns about patient care quality. Los Angeles County hospice agencies have unusually long durations of patient care and high rates of patients being discharged alive. Given that hospice patients are by definition in the last stages of their life, these trends seemingly indicate that at least some hospice agencies are enrolling patients who are not eligible for hospice services because they are not actually suffering from terminal illnesses; at the same time, those patients may experience being deprived of the curative care that they need. We also found cases where hospice agencies appear to be using the names of medical professionals without their knowledge or

Audit Highlights…

Our audit of the State's licensure and oversight of hospice agencies highlighted the following:

» *Los Angeles County has experienced a 1,500 percent increase in its number of hospice agencies since 2010.*

- *It had more than six-and-a-half times the nationwide average number of hospice agencies relative to its aged population in 2019.*

» *We found indicators of large-scale fraud that include likely fraudulent billing to Medicare and Medi-Cal and the apparent use of stolen identities of medical personnel to obtain licenses.*

» *Public Health's perfunctory hospice agency licensing process does little to verify that personnel are qualified or prevent fraud.*

- *Its limited monitoring does not adequately protect patients.*
- *It has failed to perform investigations promptly.*

» *State agencies have not adequately coordinated their fraud prevention efforts.*

- *Public Health, Health Care Services, and DOJ have not comprehensively assessed fraud risks related to hospice agencies.*

consent, thereby obtaining hospice licenses under false pretenses. In these instances, it is not clear who—if anyone—is providing care to patients.

Public Health—the state agency primarily responsible for the licensing and oversight of hospice agencies—has failed to take adequate action in the face of such widespread problems. Most critically, it has yet to issue regulations for its hospice licensing processes, despite having had the authority to do so since 1991. For example, its current initial licensing process does not require adequate screening to ensure that hospice employees are qualified to provide services to patients. Moreover, we reviewed cases in which Public Health became aware of possible fraud during the licensing process and instead of denying the licenses, it granted licenses to these hospice agencies. In these instances, it essentially enabled hospice agency operators who are possibly fraudulent to continue functioning, placing patients at serious risk of not receiving appropriate care.

In addition, we found that Public Health does not always adequately investigate complaints of patient abuse. Public Health frequently takes significant time to conclude complaint investigations, despite the short period hospice patients are likely to remain alive. In fact, the average time Public Health takes to complete a complaint investigation is more than five months—near the upper limit of a Medicare or Medi-Cal hospice patient's expected life span. Moreover, Public Health does not always conduct thorough investigations. We found instances in which it failed to interview pertinent witnesses or gather complete information, potentially endangering both the patients involved and future patients who might face abuse from the same agencies. Even when Public Health finds instances of wrongdoing, it has limited recourse to sanction hospice agencies under current state law. At the same time, it has failed to use the most powerful tools currently available to it as a means to curb violations: since 2015 it has never suspended a hospice license and has revoked a hospice license only once.

Despite these widespread problems in the hospice program, Public Health and the two state agencies primarily responsible for identifying and investigating hospice fraud in Medi-Cal—the California Department of Health Care Services (Health Care Services) and the California Department of Justice (DOJ)—have not sufficiently coordinated their efforts. The lack of such coordination has resulted in gaps in the system, which is designed to protect hospice patients from harm and to guard the State's Medi-Cal system against fraud. For example, Health Care Services and Public Health do not coordinate with each other to comprehensively assess fraud risks, such as those we found in

Los Angeles County. These siloed and disjointed efforts by state agencies are not sufficient to address the large-scale fraud that is likely occurring in the hospice industry.

Selected Recommendations

Legislature

To address the fraud that is likely occurring in Los Angeles County, the Legislature should require Public Health, Health Care Services, and DOJ to immediately convene a task force to identify, investigate, and prosecute fraud and abuse by hospice agencies in that county. It should also require these departments to establish a working group for conducting an annual risk assessment of the Medi-Cal hospice program statewide, including performing analyses similar to those we conducted during this audit regarding growth in the number of hospice agencies and clustering of hospice agencies.

To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to immediately begin the process of developing emergency regulations for its hospice licensing process. The regulations should specifically include a process for verifying the identity and qualifications of hospice agency management personnel among other items.

To ensure that hospice agencies comply with licensing requirements, the Legislature should revise state law to include a system of sanctions for Public Health to levy, including monetary fines.

We present the complete list of our recommendations starting on page 49.

Agency Comments

The Health and Human Services Agency did not provide a consolidated response to the report, but instead allowed each of its departments (Public Health, Health Care Services, and Social Services) to respond to the conclusions and recommendations that were directed to each entity. Public Health agreed with most of our recommendations but indicated that some may require additional legislation. Health Care Services, Social Services, and DOJ agreed with our recommendations to them.

Introduction

Background

Hospice is a specialized form of interdisciplinary health care primarily designed to provide palliative care and alleviate the physical, emotional, social, and spiritual discomforts of a person who is experiencing the last phases of life because of a terminal disease. Palliative care optimizes the quality of life of a patient with a terminal illness by anticipating, preventing, and treating suffering. Hospice care treats pain and other symptoms associated with a terminal disease, rather than attempting to cure the disease when a cure is no longer possible or when the burdens of curative treatment outweigh the benefits. Individuals who receive hospice care are commonly facing terminal cancer, heart disease, or neurological diagnoses, such as Alzheimer's disease. Often bedridden and cognitively impaired, hospice patients rely heavily on caregivers and are consequently one of the State's most vulnerable populations.

Hospice care is provided in the patient's home when appropriate. However, as Figure 1 describes, hospice care can also be provided in other settings, such as a hospital or skilled nursing facility, and a small number of health facilities in California specialize exclusively in inpatient hospice care. Hospice agencies use interdisciplinary teams to assess the physical, emotional, social, and spiritual needs of patients and their families. The interdisciplinary team must then develop an overall plan of care that includes the services listed in Figure 1.

More than 2,800 hospice agencies were licensed to operate in the State as of January 2022. Figure 2 shows the locations of the business offices of these licensed hospice agencies, the majority of which are in Los Angeles County. Until 2007 California had more nonprofit hospice agencies than for-profit ones. However, as of January 2022, about 94 percent of hospice agencies in California were for-profit companies. According to federal data as of August 2021, California had the highest percentage of for-profit hospice agencies of all 50 states. Federal data also indicate approximately 162,000 individuals in California used the Medicare hospice benefit at some point during 2020.[1]

Licensure and Oversight of Hospice Agencies

Under the California Hospice Licensure Act of 1990 (Licensure Act), the California Department of Public Health (Public Health) is responsible for licensing hospice agencies in the State. Licensing consists of two main components to ensure that hospice agencies comply with state

[1] Public Health does not track the number of hospice patients in the State.

Figure 1
Hospice Agencies Provide Palliative Services to Individuals Who Are Terminally Ill

In California, 94 percent of hospice agencies are for-profit companies. Each must have an **administrator** who manages the day-to-day operations as well as a business office where patient medical files and other documentation are kept.

A hospice agency uses an **interdisciplinary team** that includes:

- The patient and patient's family.
- A physician.
- A registered nurse.
- A social worker.
- A volunteer.
- A spiritual caregiver.

Hospice care consists of **services** and **supplies**, such as:

- Nursing services.
- Medical supplies, including drugs for pain management.
- Homemaker services.
- Spiritual and grief counseling.

When appropriate, hospice agencies provide care **in the patient's home**.

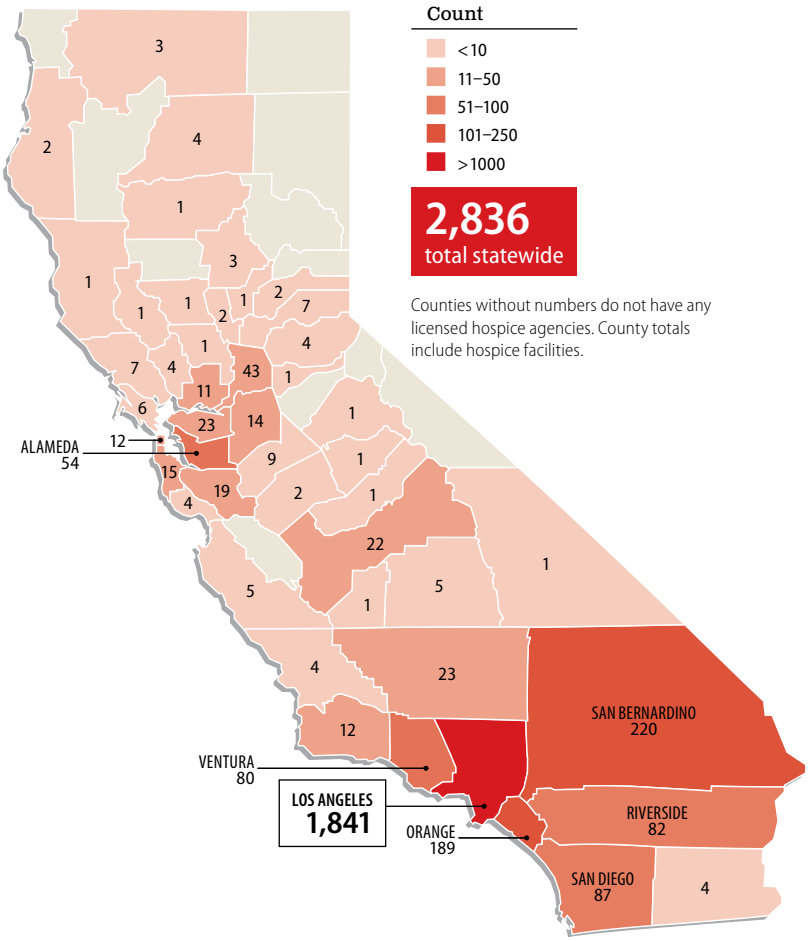
But a patient can also receive hospice care in other settings, such as a **skilled nursing facility** or **hospital**.

Source: Federal and state law, hospice standards, and Public Health's licensing data.

requirements: an application and an initial site visit.[2] State law specifies that to qualify for a license, an applicant must submit a completed application, be of good moral character, demonstrate the ability to comply with state law governing hospice care, and pay a fee of $2,971. Figure 3 illustrates the key documentation that a prospective hospice agency must submit to Public Health to demonstrate that it meets licensure requirements. Public Health's Central Application Branch reported in December 2021 having seven staff who review applications for completeness.

[2] We refer to Public Health's initial visit to a hospice agency's office before it is licensed as an initial site visit and all subsequent visits as inspections. We do so to differentiate between the initial visit, which occurs when the hospice agency is not yet operating, and subsequent visits when the hospice agency is serving patients and Public Health can assess the quality of care it is providing.

Figure 2
Hospice Agencies Are Located Throughout the State



Source: Public Health's data visualization website.

The license to operate as a hospice agency is valid for 24 months, after which the hospice agency must submit an application for renewal and a renewal fee of $2,971. Although the Licensure Act permits Public Health to inspect hospice agencies, it does not require Public Health to conduct an inspection as part of license renewal.

As part of the licensing requirements, state law requires that hospice agencies provide services in compliance with the 2003 version of the Standards of Quality Hospice Care developed by the California Hospice and Palliative Care Association (hospice standards). The hospice standards establish requirements for several aspects of hospice care, including the services an agency must provide, an agency's use of plans of care and interdisciplinary teams, and a hospice agency's staffing and administration.

Figure 3
Prospective Hospice Agencies Must Submit Specific Documentation to Public Health Demonstrating That They Meet Licensure Requirements

Key Required Documentation

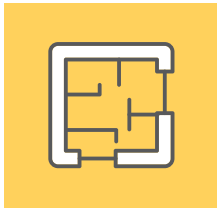
Application form

Resume/experience of key personnel

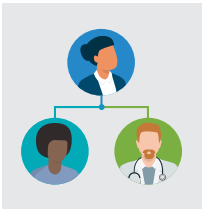
Medical licenses of proposed medical staff

Hospice agency bylaws

Geographic service area



Evidence of a physical office location, such as a lease and floor plan of hospice agency's business office space



Organization chart that identifies key personnel, including:
- Administrator *(manages day-to-day operations)*
- Medical director *(physician responsible for overall medical direction; position can be contracted)*
- Director of patient care services *(managing nurse)*
- Individuals designated to act in the temporary absence of the administrator and director of patient care services

Source: State law, hospice standards, and Public Health license application.

Public Health's 14 district offices perform the initial site visits for hospice agencies located in their jurisdictions, during which they are responsible for touring each hospice agency's office, reviewing its personnel records, and verifying that it complies with the hospice standards.

Public Health is also responsible for investigating complaints against licensed hospice agencies. It receives complaints through a variety of channels, including telephone, mail, email, its website, and referrals from other entities. When Public Health receives a complaint, it assigns it to one of its district offices based on the location of the hospice agency. District office staff review and prioritize the complaint based on its urgency. Public Health then assigns one of its staff members to complete the investigation according to a plan that identifies the necessary record reviews, interviews, and observations to attempt to substantiate the complaint's allegations. Once it completes the investigation, Public Health notifies the person who submitted the complaint of the results in writing.

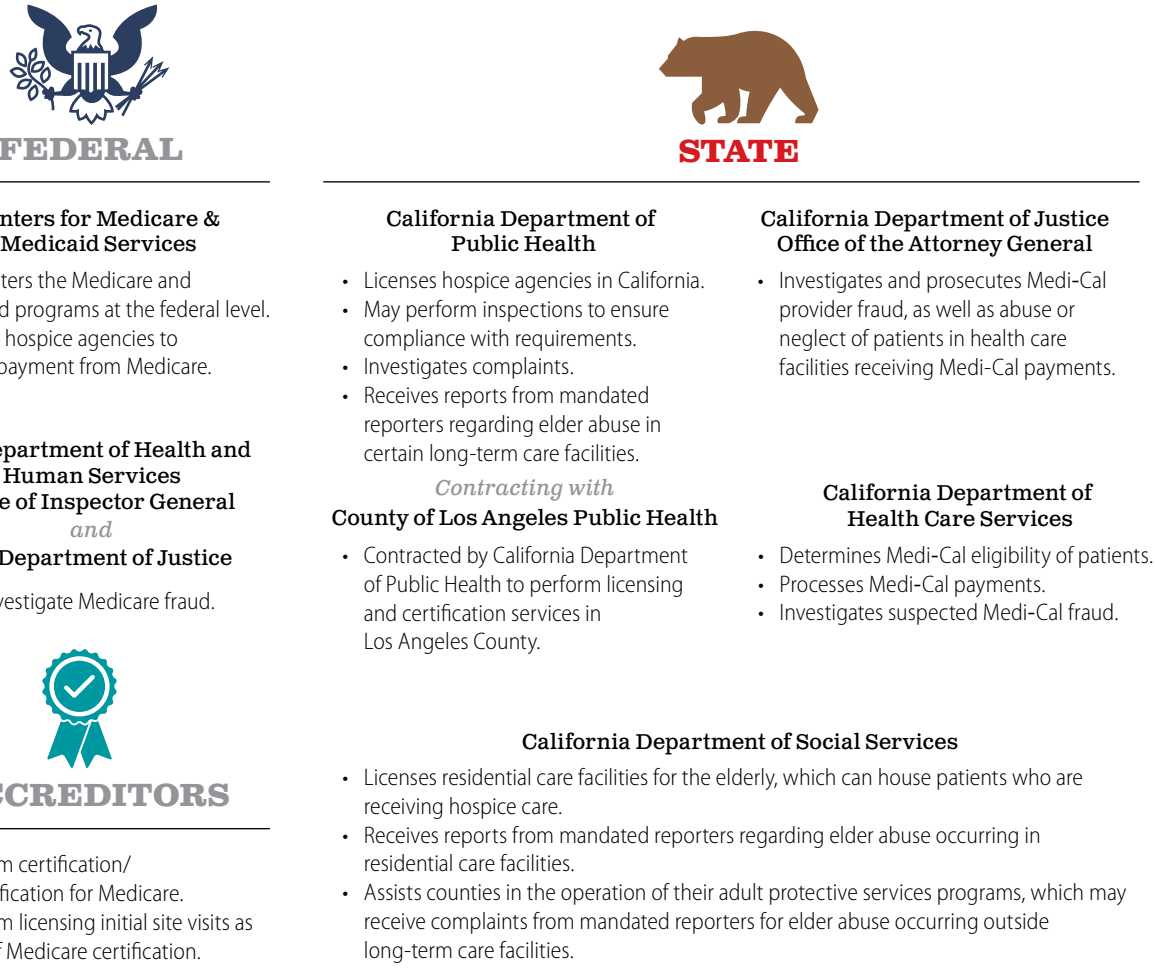
Public Health contracts with the Los Angeles County Department of Public Health to conduct licensing and certification responsibilities in that county, whereas Public Health maintains responsibility for all other counties in the State. Public Health charges license applicants an additional supplemental fee of $3,850 in Los Angeles County to cover the cost of its contract with the county. Because the Los Angeles County Department of Public Health carries out Public Health's policies and operates programs as requested by Public Health in performing its contractual licensing and certification responsibilities and because it operates under the oversight of Public Health, we do not draw a distinction in this report between the two entities.

Other federal and state entities also oversee components of hospice care, as we show in Figure 4. For example, the California Department of Social Services (Social Services) licenses and inspects residential care facilities, which may house patients who are receiving hospice services. It also assists counties in the operation of their adult protective services programs, which may receive complaints from mandated reporters for elder abuse.

Federal and State Payments for Hospice Services

To be eligible for payment from Medicare, hospice agencies must meet federal requirements for hospice care, known as *conditions of participation*. The Centers for Medicare and Medicaid Services (CMS)—the federal agency that administers Medicare—must verify that hospice agencies meet these conditions, including those listed in the text box. The Social Security Act of 1935 establishes a framework that allows state agencies to perform the Medicare certification process to determine whether hospice agencies meet federal standards, including performing certification inspections at least every three years. In California, Public Health completes these certification inspections on behalf of CMS. In

Figure 4
Various Public and Private Entities Play a Role in Hospice Oversight in California


FEDERAL
Centers for Medicare & Medicaid Services
• Administers the Medicare and Medicaid programs at the federal level.
• Certifies hospice agencies to receive payment from Medicare.
U.S. Department of Health and Human Services Office of Inspector General
and
U.S. Department of Justice
• Investigate Medicare fraud.
ACCREDITORS
• Perform certification/ recertification for Medicare.
• Perform licensing initial site visits as part of Medicare certification.
STATE
California Department of Public Health
• Licenses hospice agencies in California.
• May perform inspections to ensure compliance with requirements.
• Investigates complaints.
• Receives reports from mandated reporters regarding elder abuse in certain long-term care facilities.
Contracting with
County of Los Angeles Public Health
• Contracted by California Department of Public Health to perform licensing and certification services in Los Angeles County.
California Department of Justice Office of the Attorney General
• Investigates and prosecutes Medi-Cal provider fraud, as well as abuse or neglect of patients in health care facilities receiving Medi-Cal payments.
California Department of Health Care Services
• Determines Medi-Cal eligibility of patients.
• Processes Medi-Cal payments.
• Investigates suspected Medi-Cal fraud.
California Department of Social Services
• Licenses residential care facilities for the elderly, which can house patients who are receiving hospice care.
• Receives reports from mandated reporters regarding elder abuse occurring in residential care facilities.
• Assists counties in the operation of their adult protective services programs, which may receive complaints from mandated reporters for elder abuse occurring outside long-term care facilities.

Source: Federal and state law, CMS *State Operations Manual*, OIG website, U.S. Department of Justice website, and Public Health and Los Angeles County's licensing and certification contract.

addition, hospice agencies in California can elect to have their certification inspections performed by one of three state-contracted accreditation organizations (accreditors) instead of Public Health. We discuss in the next section the process through which hospice agencies are certified by accreditors.

Medicare is the largest payer of hospice services; in particular, it covered the costs of nearly 92 percent of hospice patient days nationally in 2018. Patients must meet certain eligibility requirements to qualify for hospice care under Medicare, including being certified as terminally ill, meaning that a hospice agency physician and the patient's attending physician, if there is one, have determined that the patient's life expectancy is likely six months or less if the illness runs its normal course. This certification covers an

initial 90-day period, after which the patient must be recertified. The hospice agency must obtain such written certification for each patient. By electing to receive hospice care, patients forgo curative treatment of the terminal illness, which Medicare will no longer cover.

In 2020 Medicare paid more than $3 billion for hospice services to 162,000 patients in the State. Medicare pays for each day a patient is in the hospice agency's care based on one of four categories, as Table 1 shows. The most common category of care is called *routine home care*. A hospice agency receives the routine home care daily payment rate regardless of the amount of service it provides to the patient on that day. This payment model can generate substantial revenue for a hospice agency. For example, for 20 patients billed at the routine home care rate that applies to the first 60 days, a hospice agency can collect more than $122,000 per month.

Although Medicare pays for the majority of hospice services in California, the State also pays for these services through Medi-Cal, the State's Medicaid program administered by the Department of Health Care Services (Health Care Services). Whereas Medicare is generally for individuals who are age 65 or over, Medi-Cal generally serves low-income individuals. Similar to the rules under Medicare, patients must meet certain requirements to elect to receive hospice care through Medi-Cal. The majority of Medi-Cal enrollees have their coverage provided by a Medi-Cal managed care plan, which pays for services through a monthly lump sum per patient. Other Medi-Cal enrollees receive their care through a fee-for-service delivery system, where providers render services and then submit claims for payment. Medi-Cal had more than 27,000 enrollees receiving hospice services in 2020. Health Care Services does not readily have information on the total Medi-Cal managed-care expenditures related to hospice services, but it provided data indicating that payments for hospice services for the fee-for-service enrollees totaled nearly $150 million in 2020.

Examples of Medicare Hospice Conditions of Participation

- **Patient's rights:** The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.
- **Initial and comprehensive assessment:** The hospice must document in writing a comprehensive assessment that identifies the patient's need for hospice care and services.
- **Interdisciplinary group, care planning, and coordination of services:** The hospice must designate an interdisciplinary group, which must prepare a written plan of care for each patient, specifying the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment.
- **Core services:** A hospice must routinely provide substantially all core services (physician services, nursing services, medical social services, and counseling) directly by hospice employees in a manner consistent with acceptable standards of practice.
- **Medical director:** The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee or is under contract with the hospice.
- **Clinical records:** A clinical record containing past and current findings must be maintained for each hospice patient, must be available to the patient's attending physician and hospice staff, and may be maintained electronically.
- **Drugs and biologicals, medical supplies, and durable medical equipment:** Those related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.
- **Personnel qualifications:** With limited exceptions, all professionals who furnish services directly must be legally authorized (licensed, certified, or registered) and must act only within the scope of his or her state license, certification, or registration. All personnel qualifications must be kept current at all times.

Source: Federal and state law.

Note: The conditions of participation above also apply to Medi-Cal in California.

Table 1
Medicare Hospice Payment Rates Depend on the Category of Care Provided

CATEGORY OF CARE	DESCRIPTION	DAILY PAYMENT RATE
Routine home care	Provided on a routine day when a patient is not receiving continuous care.*	First 60 days: $203.40 Day 61+: $160.74
Continuous home care	Provided during brief periods of crisis, consisting predominantly of nursing care to allow the patient to remain at home.†	$487.52 to $1,462.52 ($60.94 per hour)
Inpatient respite care	Provided in an approved facility on a short-term basis to relieve the caregiver.	$473.75
General inpatient care	Provided in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings.	$1,068.28

Source: Federal law and the Federal Register.

Note: Payment is generally made to the hospice agency for each day during which the beneficiary is eligible and under the agency's care, regardless of the amount of services furnished on that day.

* Routine home care days that occur during the last seven days of a patient's life are eligible for a service intensity add-on payment equal to the continuous home care hourly rate multiplied by the nursing or social work provided (up to four hours total) that occurred the day the service was provided.

† A minimum of eight hours of care must be furnished on a particular day to qualify for the continuous home care rate.

Deemed-Status Hospice Agencies

As we previously indicate, hospice agencies have historically had the ability to receive their Medicare certification through national accreditors that CMS has approved rather than through Public Health. Hospice agencies that use this process are referred to as having *deemed status*, because the accreditation is used to deem the agency as meeting the requirements for Medicare participation. Public Health contracts with three such accreditors. Effective January 1, 2019, state law requires Public Health to issue licenses to hospice agencies that are accredited by a national accreditor, provided that the accreditor forwards copies of all reports or findings related to the hospice agency to Public Health and that certain other conditions are met. About half of the State's hospice agencies currently have deemed status. For these hospice agencies, accreditors perform the initial site visit to their business offices for licensing and are required to supply Public Health with all their reports or findings from those initial visits and any subsequent inspections. The accreditors then have jurisdiction for overseeing the hospice agencies' ongoing compliance with federal requirements.

Accreditors can investigate less serious complaints about deemed-status hospice agencies, but federal law requires the State to investigate substantial allegations of noncompliance for such

agencies. If Public Health receives complaints about deemed-status hospice agencies that contain less serious allegations, it may advise the complainant to file the complaint with the accreditor or ask the complainant's permission to release the information to the accreditor. For more serious complaint allegations about deemed-status hospice agencies, Public Health must seek approval from CMS to perform an investigation that assesses the hospice agency's compliance with federal standards.

Fraud Investigations

Two state agencies are primarily responsible for identifying and investigating hospice fraud in California. As the administrator of Medi-Cal, Health Care Services investigates suspected fraud in the Medi-Cal program, including hospice fraud. In addition, DOJ's Division of Medi-Cal Fraud and Elder Abuse serves as the State's Medicaid Fraud Control Unit and investigates and prosecutes Medi-Cal fraud, including hospice fraud referred to it by Health Care Services, Public Health, and other sources. At the federal level, the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG) and the U.S. Department of Justice investigate Medicare fraud.

Recent federal reports and media articles have identified significant vulnerabilities related to the Medicare hospice benefit. Such weaknesses can result in significant financial losses for state and federal programs. For example, the OIG published two reports in 2019 that concluded that inappropriate billing by hospice agencies has cost Medicare millions of dollars and some hospice patients have been seriously harmed when hospice agencies provided poor care. The OIG indicated it has been involved in a number of hospice fraud and abuse cases that included hospice agencies that enrolled beneficiaries who were not terminally ill; these agencies also altered patient records, falsified documentation, and billed for services not provided.

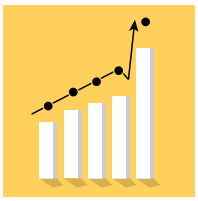
The vulnerabilities can also lead to the abuse of individuals using the programs, sometimes resulting in physical harm to these extremely at-risk patients. In its 2019 reports, the OIG identified numerous instances in which hospice agencies provided patients with inadequate care. It noted that more than 80 percent of hospice agencies it reviewed nationwide had at least one deficiency in the quality of care they provided. Many of these deficiencies, such as improperly vetting staff qualifications and failing to provide needed services, may jeopardize patient safety and care. The OIG also identified instances in which hospice agencies provided such poor care—including inadequate services to care for respiratory issues and wounds—that patients were seriously harmed. In

addition, the OIG found several cases in which hospice agencies failed to take action when their patients were harmed as a result of abuse by hospice employees and others. According to its report, one-third of all hospice agencies that had provided care to Medicare beneficiaries had complaints filed against them, and these complaints often involved poor quality of care.

In December 2020, a Los Angeles media outlet reported a high risk of fraud and harm to patients at hospice agencies in California, particularly in Los Angeles County. In addition, the U.S. Department of Justice recently identified several fraud schemes involving hospice agencies in California. For example, it charged certain hospice agency owners in the Bay Area and Sacramento with schemes in which the owners and their staff conspired to pay illegal kickbacks to employees of health care facilities and medical professionals in exchange for their referring individuals for hospice care. These same schemes have frequently also involved home health agencies, which are similar to hospice agencies in that they also provide care to patients in their homes, though hospice agencies serve patients who are terminally ill. Accordingly, we mention home health agencies in this report to the extent we identified problems that included them.

Federal and state entities have identified various indicators of hospice-related fraud and abuse. Figure 5 describes several of these indicators, which we refer to in our review. In October 2021, the Legislature passed a general moratorium on licensing new hospice agencies beginning January 1, 2022, and lasting until one year after the publication of this report, to spur attention and action to improve what many stakeholders, including hospice providers themselves, agree is a regulatory system in need of reform.

Figure 5
Federal and State Entities Have Identified Various Indicators of Hospice-Related Fraud and Abuse



Proliferation of New Providers

A high volume of newly licensed providers, particularly small for-profit agencies, could indicate fraud. Federal reports indicate that a substantial proportion of new hospice agencies have a high average length of stay, have a high live discharge rate, and are not required to report data about quality of care.

Clusters of Providers

Because hospice agencies provide services to a specific geographic area, large clusters of providers in one location suggest that the supply of providers may exceed the patient needs in that location and that the providers may actually be billing for services to patients not located in the area or who are not eligible for hospice services.

Stolen Identities

Hospice agencies may be using stolen identities of medical personnel to meet licensure requirements. They can then fraudulently bill for services purportedly performed by these individuals, who may not be aware they are named as working at the hospice agency.

Long Lengths of Service

A long length of service for patients could indicate that hospices are admitting patients who are not terminally ill and therefore not qualified for hospice care.

High Live Discharge Rates

A high discharge rate of live patients could indicate misuse of the benefit in that the hospice agencies are enrolling patients who are not eligible for hospice services because they are not terminally ill. Consequently, these patients may not be receiving the curative care they need.

Source: Federal and state reports and investigations.

Chapter 1

NUMEROUS INDICATORS SUGGEST LARGE-SCALE HOSPICE FRAUD AND ABUSE IN LOS ANGELES COUNTY

Chapter Summary

During the course of our audit, we identified numerous indicators of fraud and abuse connected to hospice agencies located in Los Angeles County. These indicators include rapid, disproportionate growth in the number of hospice agencies; excessive geographic clustering of hospice agencies; long durations of hospice services; high rates of patients discharged alive; and employees working for a large number of hospice agencies. Based on the available evidence, we are concerned that numerous unscrupulous individuals are likely creating hospice agencies and applying for licenses to fraudulently bill Medicare and Medi-Cal either for services that they are providing to patients who are ineligible for hospice care or for services that they are not providing at all. Such fraud places at risk the extremely vulnerable population of hospice patients, who are often physically and cognitively disabled and who rely on their hospice care providers to ensure that they receive adequate end-of-life care.

Los Angeles County Has Experienced Rapid, Disproportionate Growth in Its Number of Hospice Agencies

Since 2010 California has experienced an explosive growth in hospice agencies that does not appear to correlate with the need for hospice services. In recent years, a significant and disproportionate amount of this growth has been concentrated in Los Angeles County. Because hospice services are designed to provide care to terminally ill patients, we would expect the number of hospice agencies in an area to generally align with the predicted needs of terminally ill patients, namely the size of the aged population and number of deaths among the aged population. In fact, three other states we reviewed have methods in place to ensure that the number of hospice agencies closely aligns with measures of the need for hospice services. Government health agencies in those states each estimate the number of patients and need for hospice services in an area by evaluating different factors, which may include the total number of deaths, deaths in the aged population, population projections, and hospice use rates.

From its enactment in 1990 until January 1, 2022, the Licensure Act has not required Public Health to assess the need for hospice services when issuing hospice licenses. In the absence of such

measures, Los Angeles County has experienced significant growth of hospice agencies that is disproportionate to the estimated increase in its number of hospice patients and its demand for hospice services. Figure 6 shows the growth in the number of hospice agencies for Los Angeles County from 2010 through 2021. This staggering growth is largely concentrated in the cities and communities of Burbank, Glendale, North Hollywood, and Van Nuys.

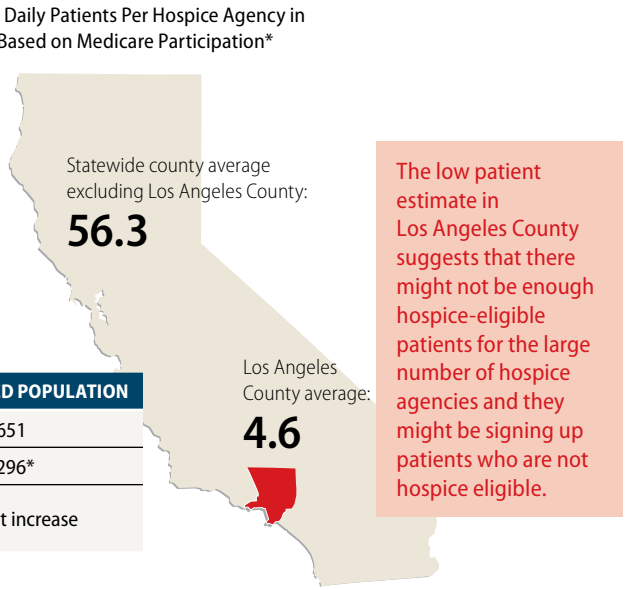
Figure 6
Los Angeles County Has Experienced Disproportionate Growth in Hospice Agencies Compared to the Rest of the State

CALIFORNIA *(excluding Los Angeles County)*

	HOSPICE AGENCIES	AGED POPULATION
2010	206	3.0 million
2021	995	4.4 million*
	383 percent increase	47 percent increase

LOS ANGELES COUNTY

	HOSPICE AGENCIES	AGED POPULATION	DEATHS OF AGED POPULATION
2010	109	1.0 million	40,651
2021	1,841	1.4 million*	63,296*
	1,589 percent increase	40 percent increase	56 percent increase


Estimated Daily Patients Per Hospice Agency in 2021 Based on Medicare Participation*
Statewide county average excluding Los Angeles County:
56.3
Los Angeles County average:
4.6
The low patient estimate in Los Angeles County suggests that there might not be enough hospice-eligible patients for the large number of hospice agencies and they might be signing up patients who are not hospice eligible.

Source: U.S. Census data, Medicare data, and Public Health's licensing data.

* We estimated the statistics for 2021 aged population, 2021 deaths of the aged population, and the daily patients per hospice agency using historical averages.

This increase in hospice agencies has led Los Angeles County to having a significantly higher number of hospice agencies in relation to its aged population than the statewide average. In 2019 Los Angeles County had more than six-and-a-half times the national average number of hospice agencies per 100,000 aged people and three-and-a-half times the statewide average when excluding Los Angeles County. In addition, the estimated number of daily patients per hospice agency in Los Angeles in 2021 is significantly lower than the statewide county average when excluding Los Angeles, as Figure 6 demonstrates. When the supply of hospice agencies appears to far exceed the number of patients eligible for and seeking such care, it suggests that unscrupulous providers may be using fraudulent or abusive methods to enroll patients who are not qualified for or who do not need their services.

Moreover, Public Health continues to be flooded with thousands of applications for additional hospice agencies, with the majority coming from Los Angeles County. From 2001 through 2018, Public Health data show it received nearly 1,700 applications for new hospice licenses. However, from just January 2019 to August 2021, Public Health received more than 3,500 licensing applications for new hospice agencies, more than double the number it received in the previous 18 years. More than 2,600, or about 75 percent, of these new hospice applications were for locations in Los Angeles County. This potential growth in hospice agencies is highly questionable. However, a general moratorium on licensing new hospice agencies in California took effect on January 1, 2022, and will last until one year from the date this report is published, which will limit the number of new hospice agencies licensed from these more recent applications for the duration of the moratorium. State law allows Public Health to grant an exception to the moratorium if an applicant has shown a demonstrable need for hospice services in its area. Further, for applications submitted after January 1, 2022, Public Health requires applicants to obtain its approval of their written justification.

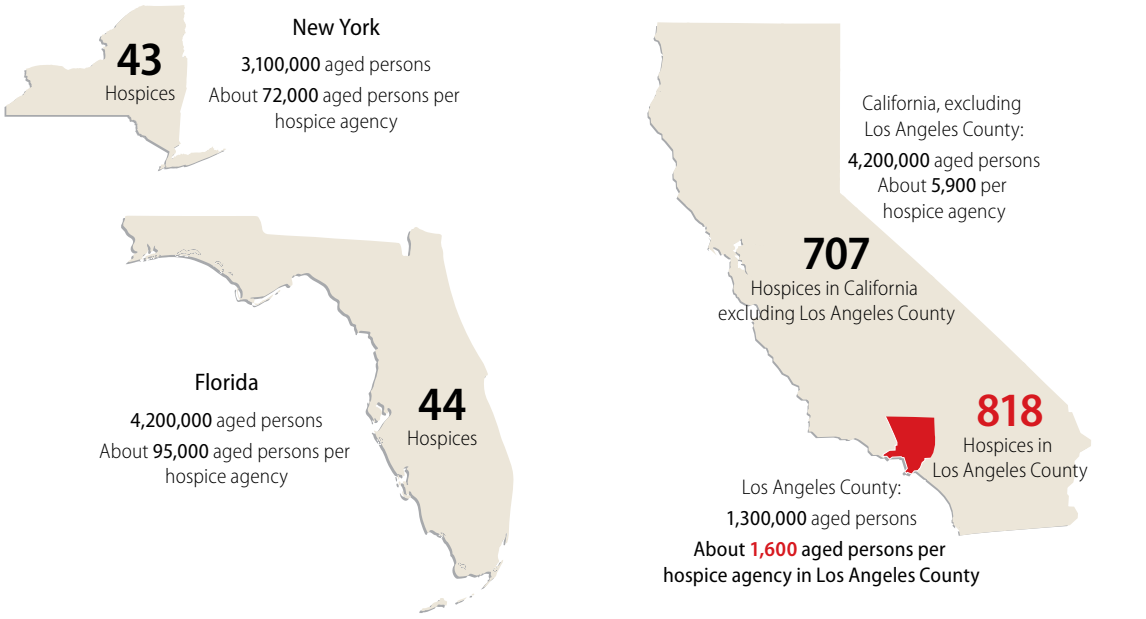
A March 2021 report from the Medicare Payment Advisory Commission (MedPAC)—an independent government entity that advises the U.S. Congress on issues affecting the Medicare program—raised concerns about the growth in new hospice agencies in California. MedPAC concluded that patterns of care among new hospice agencies in California suggest that additional oversight is warranted, particularly given the rapid entry of new providers. MedPAC also stated that the number of hospice agencies is not necessarily an indicator of access to hospice services and that hospice participation rates appear unrelated to the supply of hospice agencies. Thus, the proliferation of hospice agencies in Los Angeles County may not necessarily result in residents having greater access to hospice services.

The proliferation of hospice agencies in Los Angeles County may not necessarily result in residents having greater access to hospice services.

The number of hospice agencies in some states is significantly lower than in California. For example, New York, Florida, and Maryland each have a "certificate of need" law that requires hospice agencies to demonstrate an unmet need for hospice services in the area where they wish to operate. Figure 7 compares the number of hospice agencies in California to the number in New York and Florida in 2019.[3] The exact methodologies that these other states use to determine whether an unmet need for hospice exists vary, but they include analyses similar to the factors we discuss above, such as deaths among the aged population.

[3] During the period of our audit, the most current data publicly available for these other states was for 2019.

Figure 7
The Number of Hospice Agencies in California Far Exceeds the Number in New York or Florida (as of 2019)



New York and Florida each have laws requiring hospice agencies to demonstrate a need for services in areas in which they wish to operate.

Los Angeles County has **45 times** as many hospice agencies as New York and **59 times** as many agencies as Florida when considering aged populations.

Source: U.S. Census data, CMS data, Public Health's licensing data, and New York and Florida law.

Note: The most up-to-date data available for New York and Florida were for 2019. We used data from the same year for California and Los Angeles County for consistency in our analysis. Nevertheless, the number of hospice agencies in Los Angeles County increased significantly by 2021 to 1,841.

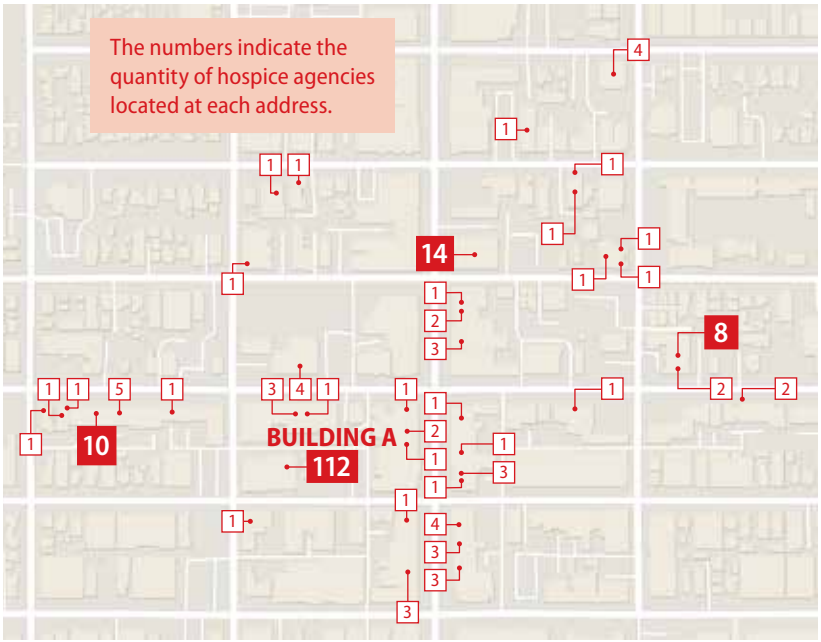
Large Clusters of Hospice Agencies Are Located at Certain Addresses in Los Angeles County

Public Health requires hospice license applicants to show evidence of a physical business office location, including a floor plan, and to have secure storage for confidential patient medical records. Accordingly, its data for hospice agencies include the physical addresses at which they are licensed. When we reviewed these data, we identified large numbers of hospice agencies with business offices at and around certain addresses. Although we acknowledge that it may be reasonable for some hospice agencies to be located in a large commercial office building, especially if that building is near a hospital or residential care facility, the significant number of clusters of hospice agencies we identified in certain areas raises concerns.

Figure 8 depicts one example of the suspicious clustering of hospice agencies in Van Nuys. Public Health's licensing data show 112 different licensed hospice agencies at one address (Building A) as well as smaller clusters in other nearby buildings. In addition to

the hospice agencies, Public Health's licensing data as of January 2022 show 49 home health agencies with business offices located in Building A.

Figure 8
Suspiciously High Numbers of Hospice Agencies Are Clustered in Specific Locations in Los Angeles County



There are business offices for 210 active hospice agencies located within 1 mile of each other in Van Nuys in Los Angeles County. We found similar clusters in the cities and communities of Glendale, Burbank, and North Hollywood in Los Angeles County. We reviewed data for the Sacramento area, the San Diego area, and the Bay Area and did not identify similar clusters of hospice agencies at a single address.

Source: Public Health's licensing data.

Building A appears to be a standard commercial office building. It lacks any exterior signage indicating any hospice agencies are housed inside. The large number of hospice and home health agencies that the licensing data show as located in this building and other businesses located in it appears to exceed its capacity. County building records show that the building has 22,500 square feet of space, and even less space is available for business offices after excluding the common areas of the building. Thus, based on the size of the building and our observations from visiting the building, there does not appear to be space for more than a total of 150 hospice agencies, home health agencies, and other businesses in the building.

The Results of Public Health's Investigation of a Hospice Agency Located at Building A

- The hospice agency door was locked, and the office phone was not working. Public Health had to contact the building's landlord to obtain the owner's contact information.
- The owner did not show up for scheduled meetings with Public Health for three consecutive days, and Public Health was not able to obtain access to any patient records, such as medical records and discharge records.
- The owner stated that her "group" had just bought the agency but had not yet submitted the change of ownership application. However, as of October 2021, Public Health's files do not indicate that a change of ownership has occurred.
- The owner was not able to answer questions regarding the agency. When asked about her title/position with the agency, the owner replied, "We have not decided yet."

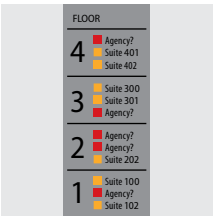
Source: Public Health's investigation documents.

Others have raised concerns regarding the legitimacy of the hospice and home health agencies located in Building A. According to Public Health's internal correspondence, CMS directed Public Health to perform complaint investigations for allegations of noncompliance that included six of the licensees in Building A. We reviewed Public Health's results of its investigations performed in January 2021 and noted several concerns related to a hospice agency it reviewed, which the text box describes. In addition, Public Health's inspections included troubling observations of staff being unavailable and patients unknowingly being admitted or not qualifying for services at certain home health agencies. Nonetheless, because Public Health indicated that it could not substantiate the occurrence of fraudulent activities at the investigated agencies, the investigation concluded with Public Health taking no action to suspend or revoke any of the licenses in question. Instead, it provided DOJ with a letter in February 2021 that identified several home health agencies and one hospice agency that it had begun investigating because of "patient care concerns and possible fraud." Public Health stated in the letter that it believes the allegations of fraud are within DOJ's jurisdiction, but it did not provide an investigation report or details about the allegations. According to DOJ, it has no record of receiving the letter. Consequently, DOJ did not pursue it.

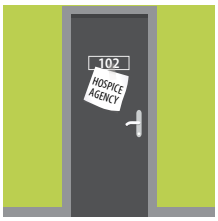
Public Health's licensing data show that a significant number of business offices for hospice agencies are similarly clustered at other addresses. We conducted visual inspections at 12 of these locations, which the data show as housing a total of approximately 240 licensed hospice agencies, to determine if the agencies were actually located in the buildings and to observe the buildings' conditions.[4] We noted that none of the buildings had external signage to indicate that hospice agencies were located within them. We also identified a number of concerns, which Figure 9 summarizes. Moreover, when we searched online for these hospice agencies, we noted the absence of business websites that would allow patients to readily locate or contact them, further calling into question their legitimacy.

[4] During our visits, we conducted visual inspections but did not knock on any doors or speak to any individuals.

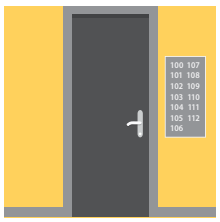
Figure 9
When Visiting the Buildings in Which Hospice Agencies Were Located, We Observed Conditions That Raised Questions About Agencies' Legitimacy



Many hospice agencies were not listed on the building directory. The building directory and suite doors listed many hospice agencies that were not included in Public Health's data for those locations.



Many suite doors had simple paper signs for the hospice agencies taped to them, sometimes over an existing permanent sign. Some suite numbers where hospice agencies should have been located had no signs or other indicators of the hospice agencies' presence.



One hospice agency suite number was included on a door with 13 different suite numbers.

One hospice agency suite had unopened mail visibly piling up on the floor inside a glass door.

Source: State Auditor observations.

Using Public Health's data, we analyzed other counties throughout the State to identify the existence of similar clusters of hospice agencies. Although we focused on other urban areas, such as Sacramento County, the Bay Area, and San Diego County, we did not identify similar clusters of hospice agencies at a single address.

The large clusters of hospice agencies in Los Angeles County suggest that the number of agencies in these areas likely exceeds the number of patients who need services. As a result, there is a high risk that the hospice agencies located in these clusters may be billing for services to patients who are either ineligible for hospice care, or who were misled and may not even know they have signed up for hospice services. As we explain in the next section, Medicare

and Medi-Cal data provide additional evidence that hospice agencies in Los Angeles County, particularly in the cities and communities where these clusters are occurring, could be engaging in fraudulent practices.

Hospice Care Trends in Los Angeles County Suggest Fraudulent Billing of Medicare and Medi-Cal

To be eligible for hospice care, a physician must determine that the patient has a life expectancy of less than six months, and state and federal agencies have identified that high rates of live discharges and long durations in hospice care are indicators of possible fraud and abuse.

According to Medicare data, in Los Angeles County as a whole and in the cities and communities we have identified in particular, discharge of patients who are still alive, known as *live discharges*, and the average number of days for which patients have received hospice services, have exceeded rates elsewhere in the State and the nation. To be eligible for hospice care under Medicare or Medi-Cal, a physician must determine that the patient has a life expectancy of less than six months. Because hospice agencies receive payment for every day that hospice patients are in their care, state and federal agencies have identified that high rates of live discharges and long durations in hospice care are indicators of possible fraud and abuse.

Live discharges from hospice care are infrequent nationwide. In some cases—about 6 percent of hospice discharges nationwide—a patient's condition may improve so that he or she is no longer considered terminally ill. Patients may also be discharged from hospice care if they revoke their hospice election to seek curative care or if they move out of a hospice agency's service area. Similarly, patients who experience poor quality of care might elect to transfer to another hospice agency, resulting in their live discharge. Nevertheless, elevated rates of live discharges could suggest that, among other things, patients who were admitted did not meet the criteria for hospice care; in other words, they were likely not terminally ill. These patients might have been admitted to hospice care under false pretenses.

In combination with high rates of live discharges, unusually long durations of hospice care can indicate that a hospice agency may be profiting from patients who do not meet the hospice criteria. Further, hospice lengths of stay vary by patient diagnosis, which permits providers to identify and enroll patients likely to have long stays if the providers believe it is financially advantageous. Although determining life expectancy is not an exact science, we would expect the lengths of stay for a provider's entire patient population to generally align with the national average over time. If a hospice agency's lengths of stay are significantly longer than these averages, it could indicate that the agency is admitting patients who do not need hospice care or is admitting them sooner than they require.

As Table 2 shows, the live discharge rates and average duration of services for Medicare beneficiaries in certain cities and communities in Los Angeles County have significantly exceeded the statewide and national averages. Moreover, our review of Medi-Cal data for hospice claims resulted in similar findings. The high live discharge rates and long average duration of services in Medicare and Medi-Cal underscore the likelihood of fraud and abuse in Los Angeles County, especially given that the cities and communities involved were those that also experienced the explosive growth and suspicious clusters of hospice agencies that we discuss previously. In fact, when we calculated the Medicare cost per patient in Los Angeles County and compared it to the national average cost per patient, the difference indicates that Los Angeles County's hospice agencies likely overbilled Medicare by $105 million in 2019 alone. Although we could not perform a similar calculation for Medi-Cal because of more limited data, we did determine that agencies likely overbilled Medi-Cal by at least $3.1 million in 2019.[5]

Table 2
2019 Medicare Hospice Patient Trends Indicate Potential Fraud in Los Angeles County

LOCATION		LIVE DISCHARGE RATE	AVERAGE DURATION OF SERVICES (IN DAYS)	AVERAGE TOTAL AMOUNT PAID PER PATIENT*
Los Angeles County	Burbank	31%	104	$17,300
	Glendale	32	89	15,100
	North Hollywood	45	110	19,300
	Van Nuys	51	102	17,000
TOTAL—Los Angeles County		**26**	**89**	**15,200**
TOTAL—California *(excluding Los Angeles County)*		**14**	**78**	**13,200**
TOTAL—National		**11**	**76**	**13,200**

Source: CMS Medicare data for 2019.

Note: Because hospice patients are in the last stages of their lives, a high live discharge rate and a long duration of services suggest that some hospices are admitting and billing for patients who are not actually terminally ill and who do not qualify for hospice care. We indicate problematic findings in red.

* Payments vary based on geographical location. However, for the purposes of this table, we used the standardized amounts that Medicare makes available in its online data.

[5] To develop this estimate, we calculated the total 2019 Medi-Cal fee-for-service payments for all hospice claims for services after patients had already received 12 months of services. However, this estimate is likely understated because limitations in the data prevented us from including similar managed care payments.

Many Hospice Agencies May Be Using Stolen Identities of Medical Professionals

Hospice agencies rely on medical professionals to coordinate and provide care to patients, as we discuss in the Introduction. Because of the critical oversight and operational duties of individuals in these positions, we would expect hospice agencies to ensure that their administrators, who are often registered nurses, and other medical professionals can commit sufficient time to performing the necessary work involved. For context, some of the hospice license applications we reviewed indicated that the administrator—the position responsible for the day-to-day operations of the hospice agency—would spend 20 to 40 hours per week at one hospice agency, ostensibly limiting that administrator to working at no more than two or perhaps three hospice agencies in total.

Nonetheless, license and certification records as of January 2022 identify 31 administrators as each working with six or more hospice agencies in the State. Of those 31, 28 administrators were listed as working for hospice agencies in Los Angeles County. In the most egregious instance, Public Health's records identify a single individual as the administrator for 27 different hospice agencies. Further, the records list several individuals as being the administrators for multiple hospice agencies in the suspicious clusters we previously discuss. Additionally, as we discuss in more detail in Chapter 2, we identified one medical director who was the active or planned medical director for more than 30 hospice agencies.

This pattern of individual administrators supposedly working for a large number of hospice agencies raises questions about whether they are actually participating in the operations of any or all of those agencies.

This pattern of individual administrators supposedly working for a large number of hospice agencies raises questions about whether they are actually participating in the operations of any or all of those agencies. Past Medicare fraud schemes have involved perpetrators using stolen identities of medical personnel to fraudulently bill for services performed by the purported employees. To evaluate whether some of these individuals might be the victims of identity theft, we reviewed their state wage data. Many did not receive wages from any of the hospice agencies for which they were listed as employees, suggesting that the hospice agencies may have fraudulently used their identities to procure hospice licenses and bill for services.

Public Health's licensing files identify instances in which medical professionals reported that hospice agencies were using their names and personal information without their knowledge or consent. We expected that when these individuals notified it, Public Health—as the State's hospice licensing authority—would have taken immediate action to investigate if fraud may have occurred and to ensure that the patients of the affected hospice agencies were receiving adequate care. However, Public Health's files do not indicate that it took action in these cases.

We find this lack of response concerning. The acting deputy director of the Center for Health Care Quality stated that it is difficult to revoke or suspend a license because the hospice agency can appeal and overturn the action. However, state law is clear that misrepresenting a material fact is grounds for license revocation, denial, or suspension. Taken in total, the evidence we found leads us to conclude that the practice of inappropriately using the identities of medical professionals to obtain hospice licenses may be common in Los Angeles County.

Public Health and DOJ Have Received Numerous Allegations of Fraud at Hospice Agencies in Los Angeles County

In addition to the significant indicators of fraud we have already noted, numerous complaints to DOJ and Public Health allege fraud, including allegations that some hospice agencies in Los Angeles County have offered kickbacks for patient referrals, admitted patients who were unaware they were signed up for hospice, enrolled ineligible patients, and falsely billed for services not rendered or required. Although DOJ and Public Health have also received complaints about fraud in other areas of the State, the number of those complaints is disproportionately lower than the number of fraud-related complaints in Los Angeles County. Data from Public Health indicate that it has received 116 complaints alleging fraud in Los Angeles County since 2015, but only 54 in the rest of the State. DOJ's data indicate that over this same period, it received 29 complaint referrals alleging hospice fraud in Los Angeles County, which it chose to review further, many of which alleged that hospice agencies had enrolled patients who were not terminally ill or eligible for hospice services.[6] At the same time, it received 32 complaint referrals related to hospice fraud for the rest of the State that it chose to review further.

When we reviewed five of the complaints that Public Health received related to hospice agencies in Los Angeles County, we found that they included allegations such as hospice agencies enrolling patients who were not in need of hospice services and falsifying medical documents to keep patients in hospice care. We provide examples of two such complaints in the text box, which illustrate the alleged inadequate care that some patients received from certain hospice agencies at the end of their lives.

Hospice Complaint Examples

Example 1

The complainant alleged that the hospice agency was falsifying documents to keep patients on hospice care and that nursing staff had not visited patients in months. The complainant also alleged that the patients were not eligible for hospice. These allegations were substantiated.

Consequently, patients who are inappropriately enrolled and kept in hospice care could lose the opportunity to seek curative medical treatment through Medicare. Additionally, patients who are not visited for months may not be receiving the appropriate care or support services.

Example 2

The complainant alleged that the hospice agency enrolled patients who were ineligible for hospice care. These allegations were substantiated.

One patient's caregiver indicated that the hospice agency had yet to fulfill its promise of providing a hospital bed but noted that the patient still wanted to be admitted to the hospital for treatment, if necessary. However, the caregiver and patient indicated they were not aware that hospice patients will not be provided with curative treatment while receiving hospice services.

Source: Public Health's licensing files.

6 Since 2015 DOJ also received 32 other complaints regarding hospice providers that it chose not to review further.

The Consistency and Number of Fraud Indicators in Los Angeles County Suggest a Large-Scale, Targeted Effort to Defraud the Medicare and Medi-Cal Hospice Programs

Each of the indicators we have described is individually concerning. More importantly, when considered as a whole, they suggest that a network or networks of individuals in Los Angeles County is engaging in a large-scale, organized effort to defraud the Medicare and Medi-Cal hospice programs. Press releases from federal law enforcement agencies and court documents have described a sophisticated, multimillion dollar Medicare fraud scheme from 2006 to 2010 that was perpetrated nationwide by an organized crime enterprise, headquartered in part in Los Angeles near the same cities and communities (Burbank, Glendale, North Hollywood, and Van Nuys) where we identified problematic trends.

This past scheme appears to have employed various methods that included some of the same fraud indicators as those we found involving hospice agencies. Specifically, in the past scheme, the perpetrators set up dozens of fake medical clinics using the stolen identities of doctors and patients to bill Medicare for millions of dollars in fictitious medical treatments. These clinics existed only on paper, without doctors or patient activity. The business addresses of these clinics were empty storefronts or locations of mailbox services. The perpetrators opened bank accounts using other fictitious or stolen identities to receive the Medicare payments on the fraudulently billed claims. They recognized that each clinic would likely be detected and shut down in a short time; consequently, they would simply move on to another fake clinic to continue their scheme.

Recent arrests further suggest that fraudulent activity is likely occurring in the cities and communities where we identified a large number of fraud indicators.

During our audit, the U.S. Department of Justice reported in December 2021 that two individuals were arrested—one from Glendale and one from Northridge—for alleged hospice fraud. It further reported that these individuals engaged in activities to fraudulently bill Medicare for hospice services that were medically unnecessary; were not eligible for reimbursement; and were not provided, including services purportedly provided to Medicare beneficiaries who did not exist. These arrests further suggest that fraudulent activity is likely occurring in the cities and communities where we identified a large number of fraud indicators. Additionally, in February 2022, the California Attorney General announced the arrests of 14 individuals who were charged in connection with two hospice companies based in San Bernardino County accused of stealing more than $4.2 million from Medicare and Medi-Cal.

Given all of the evidence, we are extremely concerned that a network or networks of individuals in Los Angeles County is setting up numerous hospice agencies and applying for licenses to fraudulently bill Medicare and Medi-Cal for services that are substandard or nonexistent—similar to past Medicare fraud schemes. We believe Public Health's ineffective licensing process, which we describe in Chapter 2, is enabling this fraud.

Chapter 2

PUBLIC HEALTH HAS FAILED TO PROVIDE THE LEVEL OF OVERSIGHT NECESSARY TO PREVENT FRAUD AND ABUSE BY HOSPICE AGENCIES

Chapter Summary

Public Health is responsible for licensing, inspecting, and investigating complaints related to hospice agencies. However, it has performed these functions incompletely and inadequately, and as a result, its oversight offers the public little assurance that hospice agencies will provide high-quality care. Its process for screening agencies' initial licensing applications fails to address instances when they hire unqualified personnel or when they establish excessively large service areas with long response times for caregivers. Moreover, because Public Health relies on hospice industry standards rather than its own regulations to guide its oversight, its initial licensing site visits do not effectively ensure adequate patient care and prevent fraud. It has also missed many additional opportunities to oversee hospice agencies because it fails to consistently obtain inspection reports from accreditors and frequently neglects to request meaningful information or perform inspections upon license renewal. Finally, Public Health's investigation of complaints involving hospice agencies is often incomplete and slow, increasing the risk that patients may receive inadequate care.

Public Health's Perfunctory Licensing Process Does Little to Identify and Deter Unqualified or Fraudulent Applicants

Public Health's lax licensing process has allowed the likelihood of large-scale fraud that we describe in Chapter 1. According to state law, the licensing process is meant to protect the health and safety of patients by ensuring that hospice agencies are qualified to provide services. However, Public Health has not issued key regulations for hospice licensing, and the current licensing requirements are inadequate to protect patients, as Figure 10 shows. In the absence of regulations, Public Health relies on certain standards written for hospice agencies. These standards, which the California Hospice and Palliative Care Association issued in 2003, provide guidance for operating hospice agencies, but they do not provide instructions for licensing and overseeing these agencies. Additionally, Public Health's efforts to verify the information that it requires are minimal, leading to a failure to adequately screen applicants.

Figure 10
Public Health's Licensing Process Lacks Critical Elements to Deter Unqualified or Unscrupulous Providers

Neither the Licensure Act nor Public Health's Regulations Address Key Gaps in Hospice Licensing Requirements

Public Health lacks requirements related to…

…criminal background checks of key hospice agency personnel.

…verifying the need for hospice agencies in proposed location.

…the size of the hospice agency's service area.

…the ratio of nurses to patients.

…staff employment by multiple hospice agencies.

Public Health Does Little to Verify Whether Applicants Meet Existing Standards

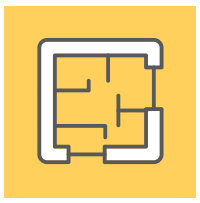
Its application review is cursory and does not adequately verify the following information applicants are required to provide:

Resume/experience

Medical license

Its initial site visit is perfunctory and does not document the following:

Verification of identities and interviews of key personnel



Verification that the physical floor plan of the hospice agency's business office matches the plan provided in the application

Source: State law, hospice standards, and Public Health's licensing application.

Although state law has authorized it to do so since 1991, Public Health has not issued key regulations that would strengthen its oversight of hospice licensing in California. In order to qualify for a hospice license, the Licensure Act requires applicants to be of good moral character, submit a completed application, satisfy the definition of a hospice, provide hospice-related services, comply with the hospice standards mentioned in our Introduction, pay a fee, and demonstrate an ability to comply with the Licensure Act, along with any hospice licensing regulations issued by Public Health. However, Public Health has failed to issue regulations to govern other key aspects of licensing. When we asked whether Public Health believes the lack of regulations is detrimental to its oversight of hospice agencies, the acting deputy director of its Center for Health Care Quality stated that the standards Public Health is required to use are outdated but that it does enforce federal standards for certification. We find this response insufficient because not all hospice agencies are federally certified and the State needs appropriate standards of its own. Public Health indicated it hopes to develop regulations in the next two years. However, we believe two years is too long to allow the significant and serious risks to health and safety we have identified to continue.

One critical consideration that Public Health has failed to adequately address in its licensing process is a hospice agency's ability to respond promptly to patient care and safety concerns. For example, Public Health has not issued regulations governing the size of the geographic area that a hospice agency can serve or the ratio of nurses to patients. Consequently, it cannot regulate whether a hospice agency can accommodate its proposed service area or adequately serve all of its patients. Although its current procedure allows each of its district offices to make its own determinations as to a hospice agency's service area size, Public Health rarely obtains evidence from hospice agencies to evaluate whether the staffing levels of the hospice agency align with its proposed service area coverage. Further, state law requires each home health agency to submit to Public Health proof of sufficient financial resources needed to operate its business as part of its licensing application. However, Public Health does not have a similar requirement for hospice agencies, even though this information would provide greater detail about the size of each hospice agency's operations.

Public Health rarely obtains evidence from hospice agencies to evaluate whether the staffing levels of the hospice agency align with its proposed service area coverage.

Public Health has issued licenses to hospice agencies with service areas of up to 31 counties, sometimes in areas of heavy traffic and long drive times. In fact, a complaint filed with Public Health alleged that dozens of hospice agencies located in Los Angeles County were providing substandard services to patients located more than 100 miles away. In our review of licensing files, we noted some instances where Public Health staff at its Sacramento County district office have raised questions as to whether the response

time from the hospice agency to patient locations was likely to be long, such as greater than an hour. However, the district office was ultimately unable to limit the size of agencies' service areas because Public Health has not established such limitations in its regulations.

Public Health has also not issued regulations to prevent hospice staff from working at many hospice agencies concurrently, a factor that directly affects patient care quality. In our review of Public Health's data and licensing files, we discovered many such cases. For instance, we reviewed an application in which the individual whom the hospice agency proposed would serve as its medical director was already the active or planned medical director for more than 30 other hospice agencies—a questionable number for a person who is charged with the responsibility of developing plans of care, directing the interdisciplinary teams, consulting with the patients' attending physicians, and liaising with other physicians in the community to coordinate efforts to ensure that each patient receives quality care. However, Public Health does not have regulations addressing this issue, and it licensed that hospice agency.

We reviewed one hospice agency application in which the proposed medical director was already the active or planned medical director for more than 30 other hospice agencies.

Even when applicants submit required information, Public Health makes insufficient effort to verify that the information is accurate. It does not consistently confirm the experience, education, resources, or character of hospice applicants. Although its procedure requires Public Health to check its system and online sources for prior management experience in hospice agencies, it does not consistently do so. Further, it does not call references to verify employment or always follow up on discrepancies when the experience cited in the application does not match licensing records. Moreover, when determining whether an applicant is of good moral character, Public Health simply requests that the applicant assert in the licensing application whether they have a criminal record. State law requires Public Health to conduct criminal background checks when approving licenses for certain other health agencies providing care in the home, such as for home health agency owners and administrators. However, state law does not have a corresponding requirement for hospice owners and administrators, which we believe places hospice patients' safety at risk.

Public Health has also failed to consistently verify the medical and nursing licenses of the professionals who work at the hospice agencies. Although its procedures require such checks for physicians and managing nurses, its staff did not document that they performed them for at least one medical position in eight of 10 licensing files we reviewed. For example, it did not verify the status of the license of a medical director whom we found had been placed on probation by the Medical Board of California for gross negligence and failure to maintain accurate medical records at the time the hospice agency reported hiring him. Further,

Public Health's procedures do not require that it verify the licenses of hospice physicians whose work is managed by the medical director. As a result, it did not identify that one such individual's medical license showed a history of probation for gross negligence and repeated negligent acts. Moreover, Public Health has not created a policy that clarifies the types of problems pertaining to a medical license that would disqualify individuals from providing hospice services.

Public Health's site visits of hospice agencies' business offices are also ineffective. Once it approves a licensing application, Public Health performs an initial site visit to ensure that the hospice agency will comply with hospice standards. Public Health performs its site visit before a new hospice agency is licensed and operating, which allows it to check for adequate office space and the ability to secure confidential personnel and medical files. However, Public Health has not developed any procedures for how to properly conduct initial site visits, other than a checklist of the hospice standards. Consequently, it lacks effective procedures to deter fraud, such as a requirement that it verify the identities of key hospice personnel. Further, some of what Public Health looks for during a site visit is impossible for it to evaluate before the agency begins operating. For example, hospice standards require the director of patient care services to devote a sufficient number of hours to the hospice agency, which is not possible to assess when the hospice agency has not yet been licensed. To be able to review such requirements, Public Health would need to perform a subsequent review after the hospice agency is licensed and operating. Consequently, the initial site visits have limited value in determining the fitness of the hospice agency to see patients.

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Even when it identifies problems with proposed hospice agencies, Public Health does not always take appropriate corrective action. Although state law allows Public Health to deny any application when it finds a misrepresentation of a material fact, it almost never does so. In fact, Public Health data show that it denied or determined to be incomplete only about 140 out of the more than 4,000 license applications it received from 2015 through 2021. However, the reasons for denial had more to do with the hospice agency not completing an aspect of the application process rather than Public Health identifying potential fraud or concerns with the qualifications of the hospice agency staff.

Perhaps most egregiously, we found instances where Public Health did not deny applications even when its staff identified information that indicated possible fraudulent behavior, such as applications containing potentially false statements. In one case, licensing staff raised concerns about a prospective hospice owner/administrator who appeared to misrepresent her qualifications on her initial

application. Nonetheless, despite not receiving sufficient evidence to address its staff's concerns, Public Health licensed the hospice agency. In another such case, an accreditor reported a concern to Public Health that a hospice agency was using a fabricated address, which was a possible indicator of fraudulent activity. Public Health simply indicated that the hospice agency needed to submit a change of location request to update the address. Ultimately, it issued the license to the hospice agency without resolving the concern the accreditor raised. Such a response ignores the possible existence of a fraudulent hospice agency, thereby jeopardizing the health and safety of hospice patients.

Public Health's Limited Ongoing Monitoring of Hospice Agencies Does Not Adequately Protect Patients

Public Health does not generally require inspections of hospice business offices or patient locations after the initial licensing site visit. According to its procedures, Public Health may perform periodic inspections, which would allow Public Health to verify that the hospice agency is providing care according to standards. However, it performs these inconsistently because its policy suggests they should happen "as needed," which is an ambiguous guideline. As a result, it is possible for hospice agencies to operate for years without any meaningful state oversight to ensure that they are providing sufficient care to their patients and are not committing fraud.

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In addition, Public Health fails to gather crucial information about hospice agencies through its biennial license renewal process. When a hospice agency is required to renew its license, Public Health sends a notification that requests that the agency pay the renewal fee and verify the names of the managing personnel recorded in Public Heath's licensing system, including key positions who are responsible for patient care such as the hospice administrator and medical director. However, for four of the eight license renewal files we examined, the notification indicated that Public Health did not have any record in its licensing system for one or more managing personnel. Public Health is unaware of whether these hospice agencies lack staff or have hired unqualified staff who could be providing patients substandard care or even causing them harm. We found no evidence that Public Health followed up in these instances to inquire about the missing information. In fact, its practice is to not seek more information in such situations during the renewal process. According to the administration section chief of the Central Application Branch, the hospice agency is responsible for notifying Public Health of personnel changes, and the absence

of personnel records in the system at the time of renewal has no bearing on whether Public Health renews the hospice agency's license—a fact we find confounding.

Public Health also does not consistently monitor when hospice licenses expire, leading to instances in which it does not know whether a hospice agency has continued to operate. During our review of licensing files, we discovered one agency whose license had been expired for nearly two years. When the license was about to expire, Public Health sent the appropriate license renewal forms and notices to the hospice agency's address of record. However, these documents were sent back with a "return to sender" notification. Public Health took no further action until we brought the issue to its attention, even though it should have searched its records for any changes and contacted the hospice agency, as its procedures require. As a result of its subsequent investigation, Public Health found that the hospice agency was no longer operating. However, it is unclear what happened to its patients and to their medical records despite the fact that hospice standards require that Public Health be notified of arrangements for the preservation or transfer of patient records to the new hospice agency as soon as a hospice agency stops operating. Public Health officials stated they are currently developing a detailed process for monitoring and following up on hospices with expired licenses.

Although Public Health requires hospice agencies to report when they change owners or locations, it has not created guidelines for when these changes require a new inspection. It instructs hospice agencies to submit a new application form when such changes take place that asks for the same information as the original licensing application, such as the names of the owners and a copy of the lease, if applicable. However, it does not have a process for enforcing the submission of this application or have a requirement to perform an inspection when these changes take place. Consequently, hospice owners can sell their businesses or move to new locations with little to no oversight for ensuring that patients will continue to receive quality care. We examined one case in which a hospice agency changed its location without Public Health requiring a new inspection. That hospice agency has since received complaints for falsifying records and neglecting patients. The acting deputy director of the Center of Health Care Quality agreed that the lack of inspections for changes of location and ownership is problematic but cited its workload as a contributing factor to its lack of its oversight on these changes.

Hospice owners can sell their businesses or move to new locations with little to no oversight for ensuring that patients will continue to receive quality care.

Public Health's weak screening process for licensing and its lack of ongoing monitoring underscore how it can enable fraud as well as patient neglect or abuse. Changing hospice agency locations and ownership can allow unscrupulous individuals to evade oversight.

In fact, there appear to be individuals who seek licensure of hospice agencies with the sole intention of selling them. We found online listings selling "brand new, never billed" hospice agencies for hundreds of thousands of dollars and promising high cash flow and profits within a few months.

Public Health Provides Very Little Oversight of Hospice Agencies With Deemed Status

As of January 2022, Public Health data showed that roughly 1,400 hospice agencies, representing half of the total number in the State, had *deemed status*. As the Introduction explains, hospice agencies with deemed status have been deemed by a federally approved accreditor to meet Medicare requirements for certification. Since 2019 state law has required Public Health to issue licenses to hospice agencies that have been approved by an accreditor as long as the hospice agency also files an application and pays fees. Accreditors perform many initial site visits and certification/recertification inspections in California. However, before issuing a license to a deemed-status hospice agency, state law requires Public Health to receive from the accreditor copies of all accreditation reports or findings. Public Health's contracts with the accreditors require them to submit the results and a copy of their full reports for each initial site visit or recertification visit to Public Health. However, Public Health has not required the accreditors to provide complete documentation of their visits showing how they ensured that hospice agencies meet federal and state requirements. Instead, Public Health receives only a letter or report providing the final determinations of whether they accredited the hospice agency, sometimes with deficiencies listed.

Public Health has not required the accreditors to provide complete documentation of their visits showing how they ensured that hospice agencies meet federal and state requirements.

In addition, Public Health has not audited any deemed-status hospice agencies, even though state law and Public Health's contracts with the accreditors authorize it to do so. These audits are intended to verify that the agencies have met hospice accreditation requirements. In the absence of any audits or the reports we discuss above, Public Health will have difficulty verifying that accreditors are complying with state law when reviewing hospice agencies.

Public Health acknowledged that it has not been collecting the information from accreditors allowed by the contracts. The interim division chief of its Center for Health Care Quality cited a heavy workload and other priorities as part of why this lapse has occurred. Nevertheless, obtaining such information about deemed-status hospice agencies is required by state law as a condition of licensure. Collecting this information should be a high priority for Public Health, given the difficulty in determining the quality of care hospice agencies provide.

In the absence of such reports, there is limited information available about the quality of care that deemed-status hospice agencies are providing. Although CMS maintains hospice quality data that includes self-reported surveys by hospice agencies, it generally requires responses only from those with more than 50 patients. Consequently, quality data on California's many smaller hospice agencies—which have increased in number in recent years—are not fully represented in the data. Public Health's data show that deemed-status hospice agencies received most of the complaints since 2019, even though they represent only half of the hospice agencies. However, Public Health does not track the number of patients each hospice agency serves, making it difficult to determine a complaint-per-patient ratio for all hospice agencies in the State.[7] Without such a ratio, we cannot perform a complete and accurate comparison between agencies with deemed status and those that go through Public Health's standard licensure process.

Nevertheless, the high proportion of complaints involving deemed-status hospice agencies is troubling, as is the lack of complete information about the quality of their services in general. Recent changes in federal law require CMS to post on its website inspection reports from a state agency, local agency, or accreditor conducted on or after October 1, 2022, which will aid with transparency in the future. Nonetheless, Public Health must make a meaningful effort to gather valuable information about deemed-status hospice agencies to ensure the safety of their patients and to prevent fraud.

The high proportion of complaints involving deemed-status hospice agencies is troubling, as is the lack of complete information about the quality of their services in general.

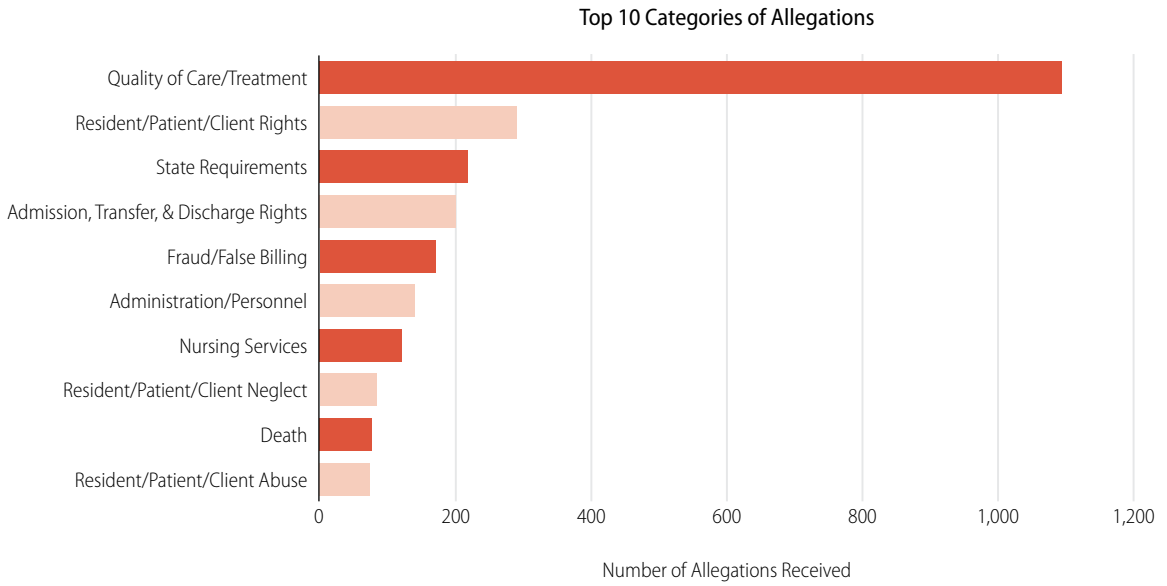
Public Health Has Failed to Adequately Investigate and Resolve Complaints Against Hospice Agencies

As we discuss in the Introduction, Public Health investigates complaints against hospice agencies. The purpose of the complaints process is to protect hospice patients from abuse, neglect, exploitation, and inadequate care or supervision. Data from Public Health indicate that it received roughly 2,100 complaints from January 2015 to August 2021, of which nearly 350 included allegations of fraud and abuse.[8] A complaint can include multiple allegations. Figure 11 shows the top 10 categories of allegations of hospice complaints that Public Health received. The 10 complaints that we reviewed included multiple allegations of fraud and abuse, such as recruitment of patients ineligible for hospice care, falsification of medical documents, and forgery.

[7] Although CMS does have data that indicate the number of beneficiaries for individual hospices, it includes data only for those that are certified.

[8] This count includes entity-reported incidents, which are incidents reported by a care provider, such as a hospice agency in this case.

Figure 11
Public Health Received Many Hospice Complaints With Allegations Related to Quality of Care (2015 to 2021)



Source: Public Health's complaint data.

However, Public Health's investigations of these 10 complaints were not always thorough and as a result, it is unclear if the alleged actions of some actually occurred. According to its policies and procedures for investigating complaints, Public Health substantiates an allegation by verifying with evidence that it occurred. Of the 10 complaints we reviewed, Public Health substantiated allegations in two complaints of neglect: one involved a patient that passed away, and the other alleged that the end of a patient's life was worsened and hastened. Public Health substantiated allegations in another four complaints of fraud and abuse, and it concluded that the remaining four complaints were unsubstantiated. However, Public Health may identify an allegation as unsubstantiated for two quite different possible reasons: it may conclude, based on evidence, that the alleged action did not occur, or it may conclude that it cannot make a determination as to whether the alleged action occurred because there is a lack of sufficient evidence to reach a conclusion. There is a significant difference between these two outcomes.

Some allegations included in complaints likely go unsubstantiated because Public Health does not always seek sufficient evidence when it investigates them. Its investigative process entails reviewing documentation, making observations, and interviewing hospice personnel and other relevant individuals. As an initial step, it requires its staff to complete an investigation plan, which is intended to identify the interviews it intends to conduct and the documents it will review to

ensure that it addresses each allegation. Nevertheless, for eight of the 10 complaints we reviewed, Public Health could not provide us with any support showing that it created such a plan. Furthermore, the complaint investigation files did not always include robust evidence: seven of the 10 complaint files we examined either had inadequate evidence because Public Health did not gather or review proper documentation or because it did not interview all relevant individuals. Specifically, it failed to interview medical personnel, patients, and family members to gather critical information about the alleged events.

In addition, Public Health has not always investigated complaints in a timely manner. Based on the time frames it established, Public Health requires an onsite investigation to be initiated within two working days for complaints that are classified as *immediate jeopardy*—a situation in which the patient has been or is at risk of serious injury, harm, impairment, or death. For nonimmediate jeopardy complaints that are high priority—a situation in which the patient has been or is at risk of harm that impairs mental, physical, and/or psychosocial status—Public Health's time frame for initiating the investigation is up to 45 calendar days. For both immediate jeopardy and nonimmediate jeopardy high priority complaints, Public Health's time frame for completing the investigation is 30 days after the evaluator completes the onsite investigation. Thus, the expected completion date will vary depending on the investigation and is not a standard number of days. Consequently, this approach does not impose any meaningful limit to the amount of time Public Health takes to investigate a complaint. From 2015 through 2020, Public Health data show that it took an average of 163 days to complete its investigations. The long period to complete investigations can allow fraud, abuse, and neglect to continue.

Public Health's approach to investigations does not impose any meaningful limit to the amount of time it takes to investigate a complaint.

In one particularly egregious instance we reviewed, Public Health did not complete its investigation of a complaint until more than a year after first receiving it. In this instance, a complainant alleged that the hospice agency was not managing a patient's insulin appropriately, causing episodes of low blood sugars that greatly diminished the patient's quality of life and could possibly hasten the patient's death. Public Health classified the complaint as immediate jeopardy and performed an onsite investigation within its recommended time frame. However, it did not communicate the results of the investigation to the hospice agency and complainant until more than a year later. When asked about the reason for the delay in resolving this complaint, Public Health explained that at the time it did not prioritize complaints that did not involve long-term care facilities, such as the one we reviewed, and that a high workload and lack of staff contributed to this delay. In this instance, Public Health indicated it promptly ensured the patient was safe.

However, concluding an investigation so late is unreasonable, particularly in a case that involves a terminally ill patient and potential abuse.

The Licensure Act does not currently have monetary penalties that Public Health can use to sanction hospice agencies that exhibit deficiencies, and—as we discuss further in Chapter 3—it rarely uses its authoritative power of revoking a hospice agency's license. As a result, we are concerned that it is enabling fraud, abuse, and neglect to continue or reoccur, thus risking the health and safety of vulnerable hospice patients.

Chapter 3

STATE AGENCIES HAVE NOT ADEQUATELY COORDINATED THEIR FRAUD PREVENTION EFFORTS OR DEVELOPED MEANINGFUL ENFORCEMENT MEASURES FOR THE MEDI-CAL HOSPICE PROGRAM

Chapter Summary

Public Health and the other two state agencies that play a role in identifying and investigating fraud and abuse of the hospice system—Health Care Services and DOJ—have done little to coordinate their efforts. This lack of coordination appears to have resulted in significant flaws in a system that is designed to protect vulnerable hospice patients from harm and to guard the State's Medi-Cal system against fraud. Further, Public Health has not sought statutory sanctions to enforce hospice requirements and has revoked a hospice license only once since 2015, even though revocation is its most powerful tool for stopping fraud and abuse. Finally, Public Health has not consistently provided members of the public with essential information about hospice agencies so that they can make educated decisions about the care they and their families receive.

The State Does Not Coordinate Its Efforts to Curb Hospice Fraud

Health Care Services' mission for investigating fraud is to protect and enhance the integrity of the health programs it administers, including the Medi-Cal hospice program. According to best practices, critical steps toward achieving such a mission include performing a comprehensive risk assessment and developing fraud prevention measures. We expected that Health Care Services would be coordinating with Public Health and DOJ—the other state agencies with responsibilities for hospice oversight—to comprehensively identify and assess risks to the Medi-Cal hospice program and to develop improvements that address weaknesses and prevent fraud and abuse. However, when we reviewed Health Care Services' efforts regarding the Medi-Cal hospice program, we found that it had not completed a comprehensive risk assessment, that its efforts were largely reactive, and that it had not established substantive preventive measures. The text box describes the elements of a comprehensive risk assessment.

Elements of a Comprehensive Risk Assessment

- Identify specific fraud schemes and risks.
- Assess their likelihood and significance.
- Evaluate existing fraud prevention and detection activities.
- Implement actions to mitigate remaining fraud risks.

Source: Committee of Sponsoring Organizations of the Treadway Commission's *Fraud Risk Management Guide*.

Health Care Services analyzes hospice fraud only on an individual provider basis, rather than assessing risks to the Medi-Cal hospice program as a whole.

To identify hospice agencies for additional investigation, Health Care Services developed a hospice profiler tool that it uses to compare certain risk indicators among hospice agencies using Medicare and Medi-Cal claims data. However, the risk indicators that the tool employs may not be adequate because Health Care Services has not performed a formal comprehensive risk assessment for the hospice program as a whole. For example, it has not assessed the explosive growth in hospice agencies that has occurred in recent years, which appears likely driven by fraudulent providers. Because Health Care Services narrowly focuses on individual agencies without taking into account the broader trends that are occurring in the program, it is likely to miss significant indicators of fraud, such as the growth and clusters of hospice agencies. Further, without this information, Health Care Services cannot recommend broader policy changes or implement practices that would help to address and prevent fraud.

Health Care Services does not leverage the knowledge about hospice risks in its risk assessment that Public Health has gained through inspections and complaint investigations.

Moreover, Health Care Services does not coordinate with Public Health to obtain information that should factor into Health Care Services' risk assessments. In particular, Health Care Services does not leverage the knowledge about hospice risks in its risk assessment that Public Health has gained through inspections and complaint investigations. This information could not only provide Health Care Services with additional fraud indicators, but it could also serve to identify gaps in the regulatory and oversight processes that are currently in place.

Similarly, DOJ and Public Health do not adequately coordinate their efforts to investigate and prosecute fraud in the Medi-Cal hospice program. When we reviewed a list of hospice fraud-related complaints that DOJ had received, we found that DOJ did not investigate 29 complaints that Public Health referred to it from 2016 through 2021. According to DOJ, Public Health did not provide it with sufficient evidence for DOJ to effectively investigate the referred complaints. However, DOJ does not have a documented procedure to reach out to Public Health in order to gather additional details regarding referrals. Consequently, the State lacks an effective process for moving complaints forward that might merit investigation.

Finally, Public Health's and Social Services' fraud prevention efforts related to hospice care at residential long-term care facilities are minimal. According to the assistant program administrator of Community Care Licensing at Social Services, the facilities themselves are responsible for coordinating with the hospice agencies that provide care to their residents. However, during the course of our audit, we found complaints alleging that hospice agencies had targeted residents of long-term care facilities to become hospice patients, sometimes

through fraudulent means. Currently, Public Health and Social Services do not identify or analyze complaints against hospice agencies that involve these residents. We believe that the targeting of residents in long-term care facilities underscores the need for these state agencies to coordinate their efforts to notify residents of such risks.

Public Health Has Not Sought Statutory Sanctions to Enforce Hospice Requirements

Public Health has not sought the establishment of statutory sanctions as a means to protect patients from violations of state hospice care standards. State law authorizes the imposition of monetary sanctions to protect the health and safety of individuals receiving care in settings such as long-term care facilities and hospitals. However, according to the acting deputy director of the Center for Health Care Quality, Public Health has not sought statutory changes to establish civil fines or other sanctions to address serious problems relating to hospice care, such as harm to patients.

Recently, CMS made changes to federal hospice oversight that impose additional sanctions on hospice agencies that are similar to those for home health agencies, including the suspension of Medicare payments and the imposition of fines. For example, CMS can fine home health agencies up to $10,000 per day of noncompliance that constitutes an immediate jeopardy violation that results in harm. CMS's new rule applies these sanctions to hospice agencies. However, the Licensure Act lacks meaningful sanctions for violations of state law or hospice standards.

The Licensure Act lacks meaningful sanctions for violations of state law or hospice standards.

Moreover, Public Health does not use the methods currently available to it to ensure that hospice agencies comply with its requirements. State law allows Public Health to deny licensing applications and to suspend or revoke licenses for several reasons, including if the hospice applicant has felony convictions, misrepresents facts, or violates licensure rules. Public Health can also impose fines when hospice agencies violate patient data privacy laws. However, as we indicate previously, it rarely denies license applications. In addition, Public Health records show it has revoked a hospice license only once since 2015, even though license revocation is the most powerful tool currently available to it as a means to curb violations. Public Health's data show that since 2015, it has cited more than 60 hospice agencies each with more than 20 violations. Yet it has not taken action to suspend a license since 2015, thereby missing the opportunity to immediately halt the operation of hospice agencies that have serious deficiencies. According to Public Health officials, it is difficult to revoke or suspend a license because the hospice agency can appeal,

which can result in overturning the action. However, by not carrying out the enforcement measures available to it, Public Health neglects to perform its duty to ensure the health and safety of hospice patients.

Public Health Does Not Report Essential Information to the Public About Hospice Agencies

Public Health administers the California Health Facility Information Database (Cal Health Find), a repository of information about health care facilities, including hospice agencies. Public Health shares this information with the public through its Cal Health Find website to provide consumers with health care provider information, such as licensing and certification status, and complaints and deficiencies. Like similar websites provided by other government entities, Cal Health Find presents details about each hospice agency, including the owner and any substantiated complaints. Further, Cal Heath Find provides information about the process for submitting complaints against hospice agencies. It also includes a comparison feature like the one used in CMS's Care Compare website that allows users to compare health care providers.

Cal Health Find has outdated information related to ownership and licensing status of hospice agencies, which limits its usefulness to the public.

However, as Figure 12 shows, Cal Health Find's website lacks key information that would help members of the public make well-informed decisions when choosing a hospice agency. First, Cal Health Find has outdated information related to ownership and licensing status of hospice agencies, which limits its usefulness to the public. Although Public Health says that it updates the website weekly using the licensing information in its database, we identified a number of instances in which the website did not reflect current information. In one case, Public Health posted the results of a complaint investigation in Cal Health Find that concluded, in part, that a hospice agency was not at its stated address. In fact, that hospice agency notified Public Health that it stopped operating in October 2019 after which its license was never renewed. Nevertheless, as of February 2022, Cal Health Find continued to list that hospice agency's license as active. Consequently, an individual reviewing the website who is making decisions about hospice care would not have accurate information about that agency's actual status.

Additionally, although Cal Health Find includes details of substantiated complaints, it provides limited information about unsubstantiated complaints, which includes cases where the investigation results lacked sufficient evidence to conclusively support the allegation. In contrast, the Community Care Facility Search website—which contains information on residential care facilities that Social Services licenses—includes unsubstantiated complaint allegations and a full report of the actions investigators took to reach their final determinations. It thus provides the public with useful perspective for making informed

Figure 12
The Cal Health Find Website Does Not Contain Critical Information About Hospice Agencies That Would Increase Transparency

Cal Health Find does not:

- Contain current information about hospice agency ownership and licensing status.
- Indicate whether an allegation was deemed unsubstantiated for lack of evidence or because it was proven untrue.
- Include a rating system that would allow users to easily determine the quality of the services the hospice agency provides.
- Include an icon that indicates whether a hospice agency has been cited recently for abuse or neglect.

Source: Cal Health Find and other state and federal websites.

Note: We compared Cal Health Find with similar websites administered by CMS and Social Services, both of which contain searchable databases of health care facilities' licensing and complaint information.

decisions. We explain in Chapter 2 that Public Health is unable to substantiate some complaints related to hospice agencies simply because it is unable to gather sufficient evidence, which is different from those complaints that it is able to conclude that the allegations are untrue. We believe that Public Health should differentiate these outcomes into two categories on its website: unsubstantiated—indicating that the allegations have been proven untrue—and undetermined—indicating that there was not enough evidence to make a determination. Those who rely on the Cal Health Find website would be better informed and better protected if Public Health shared this specific detail, thus ensuring full disclosure and transparency.

Finally, the Cal Health Find website does not include indicators of performance quality. CMS's Care Compare website includes multiple measures of performance to help users make decisions about nursing homes. For example, it includes a facility rating system based on recent annual inspection results, staffing levels, and quality measures that take into consideration factors like the percentage of residents who have been injured in falls. Another indicator of facility quality on the Care Compare website is the abuse icon, which labels facilities that have been recently cited for abuse or neglect. This icon allows users to quickly identify potentially problematic facilities. Once the facility resolves the problem, the icon is removed at the next monthly update of the website, which gives facilities the incentive to quickly address conditions leading to abuse or neglect. By adopting a similar rating system and indicators into Cal Health Find, Public Health could ensure that members of the public have easy access to this critical information they need to select a hospice agency.

Conclusions and Recommendations

The State has a responsibility to ensure patient safety by ensuring that hospice agencies are qualified to provide services. However, under Public Health's lax oversight, many hospice agencies have become licensed too easily, thereby enabling unscrupulous individuals to take advantage of extremely vulnerable patients and their families. We believe immediate action needs to be taken to ensure the health and safety of hospice patients and to address the significant likelihood of fraud occurring in Los Angeles County. One of our key recommendations is for the Legislature to require Public Health to issue emergency regulations that address key gaps in hospice licensing requirements, a much-needed step that Public Health has neglected to take for the past three decades. The Legislature has imposed a general moratorium on licensing new hospice agencies until one year following the publication of this report to spur action to improve a regulatory system in need of reform. Thus, we have directed many of our recommendations to the Legislature.

We believe that a coordinated effort by Public Health, Health Care Services, DOJ, and Social Services is necessary not only to respond to instances of fraud and abuse, but also to proactively prevent future occurrences. Collaboration among these departments is critical. Considered as a whole, the rampant growth, the indicators of large-scale fraud, and the limited oversight that characterize the hospice industry in California signify the need for prompt legislative changes to protect patients.

Recommendations

Legislature

To address fraud that is likely occurring in Los Angeles County, the Legislature should require Public Health, Health Care Services, DOJ, and Social Services to immediately convene a taskforce to identify, investigate, and prosecute fraud and abuse by hospice agencies in that county. It should also require those four departments to establish a working group to annually meet to conduct a risk assessment of the Medi-Cal hospice program statewide, including performing analyses similar to those we conducted during this audit regarding growth in the number of hospice agencies, clustering of hospice agencies, and instances of medical personnel working at multiple hospice agencies. Because the fraud indicators we identified frequently also involved home health agencies, the four departments should also consider risks

related to home health agencies. These departments should adjust their fraud prevention and detection efforts based on the results of this assessment.

The Legislature should require fraud training for any Public Health staff who are responsible for licensing and certifying hospice agencies, including training about the types of information that are necessary for making referrals to DOJ when they suspect fraud is occurring.

To help ensure that hospice owners and hospice management personnel are of good moral character, the Legislature should revise state law to require that each hospice agency's owners, and the hospice agency's administrator, director of patient care services, administrator/director of patient care services designee, and medical director (hospice management personnel) submit electronic fingerprint images to DOJ for the furnishing of the person's criminal record to Public Health. The revision should also include a requirement that hospice owners and management personnel with certain criminal convictions, as determined by the Legislature, are prohibited from obtaining a license and are further prohibited from providing any hospice-related service before obtaining either a criminal record clearance or a criminal record exemption from Public Health.

To protect against excessive and fraudulent growth in the number of hospice agencies, the Legislature should revise state law to require new, previously unlicensed hospice agencies to demonstrate an unmet need for hospice services in an area where they wish to operate. The law should require that the number of hospice agencies in a given geographic region closely aligns with measures of the need for hospice services. It should also define appropriate measures of need and identify the methodology hospice agencies must use to demonstrate need.

To enable Public Health to better oversee the licensure of hospice agencies, the Legislature should require as a part of the licensure application the inclusion of financial information that is similar to the information required for home health agencies.

To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to issue emergency regulations within one year, while maintaining the general moratorium on new hospice licenses until Public Health issues the regulations. The emergency regulations should do the following:

- Establish time and distance standards that define the maximum time and distance hospice agency staff may travel to reach patients, taking into consideration typical traffic conditions and whether the hospice agency is serving patients in rural or urban areas.

- Establish guidelines for assessing the appropriateness of a hospice agency's ratio of patients to nurses.

- Establish a limit to the number of hospice agencies that hospice management personnel can be involved with concurrently.

- Require hospice management personnel to have hospice-specific training or experience.

- Require, as part of its review of the initial application, that Public Health verify that the hospice management personnel listed on the licensing application are, in fact, associated with the hospice agency, such as by contacting them by phone, and verify the work history of hospice management personnel by speaking with these individuals' previous employers by phone.

- Require Public Health to verify the status of the professional licenses for all hospice medical personnel, including contracted medical directors, as part of the initial license application. The regulations should also establish guidelines for when Public Health must deny the application of a hospice agency that is proposing to use medical personnel whose professional license records indicate the imposition of a disciplinary action. For instance, probation for gross negligence or fraudulent billing should be a cause to deny a hospice agency's application, even if the medical director's license is currently active.

- Establish requirements for conducting an initial licensing site visit that include verifying the identities of all hospice personnel and ensuring that the hospice agency is set up to provide adequate care. Public Health should develop specific requirements for hospice office space and verify compliance with those requirements during the initial site visit.

- Establish requirements for follow-up inspections to the initial site visits within one year of initial licensing to verify that hospice agencies are complying with those hospice standards that cannot be assessed before the agencies begin providing care to patients. These inspections should be unannounced and take place after the hospice agency has begun caring for patients. During these inspections, Public Health should visit patients, ensure that the certifications of terminal illness are accurate, confirm that the hospice agency is providing adequate care, check hospice personnel identities and medical licenses, and ensure that the hospice agency has reported any personnel changes.

To ensure that all licensed hospice agencies comply with Public Health's newly adopted regulations, the Legislature should revise state law to require Public Health to conduct a license

renewal for all currently licensed hospice agencies within two years after the regulations are adopted. It should also revise state law to require Public Health to perform license renewal inspections for all licensed hospice agencies periodically. If it performs them at least every 18 months, every other cycle will coincide with Medicare recertification inspections, which are required at least every 36 months.

To increase oversight of deemed-status hospice agencies, the Legislature should amend state law to require Public Health to do the following:

- Collect and monitor full reports from accreditors for all current and future deemed-status hospice agencies.
- Annually audit a selection of at least 5 percent of deemed-status hospice agencies and monitor these agencies to ensure that they take any necessary corrective actions.

The Legislature should revise state law to include a system of sanctions for Public Health to levy, including fines or license revocation, for the following:

- Violations of state law, regulations, or hospice standards by a hospice agency, including improperly certifying a patient as eligible for hospice care.
- Failure by hospice management personnel to be present for an inspection or complaint investigation.
- Failure by a hospice agency to report a change in owner, hospice management personnel, or location.

To ensure that Public Health appropriately addresses the complaints it receives, the Legislature should require it to do the following:

- Establish time frames within which Public Health must initiate and complete its investigations of hospice complaints.
- Develop a comprehensive training manual regarding performing investigations. The manual should include specific guidance for interviewing witnesses, collecting and reviewing documents, and following up on discrepancies to properly and thoroughly address complaints.

To help ensure that residents of long-term care facilities are not taken advantage of by unscrupulous hospice agencies, the Legislature should require Public Health and Social Services to develop materials to educate current and future residents of these

facilities and their families about common hospice fraud schemes, including efforts to mislead residents to sign up for hospice care. It should also require Public Health to include this information on its website.

To ensure that the public has adequate information when selecting a hospice agency to provide care, the Legislature should require Public Health to revise its Cal Health Find website by October 2022, to include the following:

- Up-to-date information about the ownership and license status for each hospice agency licensed by Public Health.
- Specific identifiers to differentiate between complaints that were unsubstantiated based on a review of sufficient evidence and complaints that were undetermined because it could not reach a conclusion because of lack of evidence.
- A quality-of-care rating system for hospice agencies similar to the one that CMS uses for Care Compare. After all hospices have been inspected based on the new regulations, Public Health should begin reporting the quality-of-care ratings.
- An indicator or icon identifying a hospice agency that has received citations for abuse and neglect in the past year.

DOJ

To improve its ability to investigate possible fraud and abuse, DOJ should provide guidance to Public Health about the types of information Public Health should include when it refers complaints that allege fraud to DOJ. Further, DOJ should also document a procedure for following up on complaints that do not include adequate information.

Public Health

Until such time as the Legislature authorizes Public Health to issue the emergency regulations described above, Public Health should pursue its standard regulatory authority to address these issues.

We conducted this performance audit in accordance with generally accepted government auditing standards and under the authority vested in the California State Auditor by Government Code section 8543 et seq. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

MICHAEL S. TILDEN, CPA
Acting California State Auditor

March 29, 2022

Appendix

Scope and Methodology

The Joint Legislative Audit Committee (Audit Committee) directed the California State Auditor to conduct an audit of Public Health and Health Care Services to determine whether they are adequately overseeing hospice agencies. It specifically asked that we evaluate the growth in the number of hospice agencies in California, the scope of hospice fraud and abuse, and the effectiveness of licensing processes for screening applicants. The table below lists the objectives that the Audit Committee approved and the methods we used to address them.

Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed laws, rules, and regulations related to the regulation of hospice agencies in California.
2	Evaluate the growth of hospice agencies in California over the last decade, including the potential factors that led to this growth, and determine whether other states have experienced any such growth and taken steps to address it.	• Analyzed Public Health's licensing data to determine the growth in the number of hospice agencies in California. • Evaluated potential factors that led to the growth in the number of hospice agencies in California. • Identified the four next most populous states (New York, Florida, Texas, and Pennsylvania) and evaluated growth in their hospice agencies using CMS's data. • Evaluated the laws and regulations of certain other states to limit growth in the number of hospice agencies.
3	Assess the scope of hospice fraud and abuse in California and the impact of such fraud on the Medicare and Medi-Cal programs by doing the following: a. Examine potential factors related to the growth of hospice fraud in California, including Medi-Cal fraud and abuse, and determine what types of hospice fraud are most prevalent and whether Public Health and Health Care Services could do more to protect older Californians from hospice scams. b. Evaluate the impact of hospice fraud and abuse on Californians who have been victim to it. c. Evaluate the effectiveness of California's systems to identify, address, prosecute, and deter hospice fraud and determine whether additional resources may be needed. Identify whether the systems are effective at preventing Medi-Cal from certifying unqualified providers. d. Identify and describe annual Medi-Cal program spending on hospice care for Medi-Cal beneficiaries and how this may have changed over the last decade. To the extent possible, evaluate the financial impact of hospice fraud in the Medi-Cal system.	• Reviewed press releases and court documents from federal and state law enforcement agencies related to hospice fraud and abuse and other health care fraud schemes. • Reviewed Public Health's hospice location data to identify hospice agencies clustered in specific locations. • Reviewed Public Health's hospice licensing data and licensing files to identify hospice personnel purportedly working for multiple hospice agencies. • Analyzed Medicare and Medi-Cal spending data for hospice services to determine the impact of hospice fraud. • Evaluated efforts by Public Health, Health Care Services, Social Services, and DOJ to identify, address, prosecute, and deter hospice fraud. • Reviewed spending data from Health Care Services for 2011 through 2020 to determine the amount of Medi-Cal fee-for-service funds spent for hospice care. • We are referring information related to possible fraud to DOJ and the federal OIG for investigation.

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	AUDIT OBJECTIVE	METHOD
4	Evaluate reporting of hospice abuse and neglect in California and, to the extent possible, assess compliance with mandated reporting requirements. Determine how the State could strengthen reporting requirements and related enforcement.	• Reviewed state law related to mandated reporting, as well as Public Health's and Social Services' relevant procedures. • Interviewed staff at Public Health and Social Services regarding their implementation of mandated reporting procedures. Social Services forwards mandated reports regarding hospice agencies to Public Health, which handles mandated reports it receives in the same way it handles complaints, which we addressed as part of Objective 11.
5	Evaluate the State's coordination of services between nursing and assisted living facilities and hospice agencies by doing the following: a. To the extent possible, assess a potential trend in California targeting residents of nursing and assisted living facilities to receive hospice care. b. To the extent possible, examine whether the residents of long-term care facilities and state and federal payers are getting full value for hospice care. c. Assess whether Health Care Services and Public Health have sufficient authority and resources to effectively monitor and evaluate the appropriateness, adequacy, and quality of hospice services provided to residents of nursing and assisted living facilities and to evaluate coordination between hospice providers and long-term care facilities.	• Reviewed an interagency agreement pertaining to the coordination of hospice care, as well as relevant procedures of Public Health, Social Services, and Heath Care Services, including state law pertaining to patient recruitment. • Interviewed staff at Public Health, Social Services, and Health Care Services to determine the methods they use and extent to which they monitor patients in long-term care facilities who choose to receive hospice care. • Obtained complaint data and interviewed Public Health staff to determine whether it tracks hospice agencies targeting residents of long-term care facilities. • Determined that because hospice agencies receive payment for every day that a patient is under their care, regardless of whether they provide services that day, it is difficult to evaluate whether payers are getting best value for hospice care.
6	Assess the adequacy of hospice agency information presented on Public Health's Cal Health Find website to determine whether improvements and additional information may be necessary to better serve the public.	• Compared Cal Health Find to similar websites administered by Social Services and CMS to evaluate the adequacy of the information it includes about hospice agencies and to identify useful improvements. • Compared hospice agency information on Cal Health Find to licensing files and publicly available news reports to determine whether the website is current and complete.
7	Determine the percentage of state hospice agencies that are for-profit providers and compare it to the rest of the nation. Evaluate the factors contributing to the prevalence of for-profit hospice agencies in the State and analyze their potential impacts on hospice services and hospice fraud.	• Analyzed Public Health's licensing data and CMS's data on hospice agencies in other states. • Reviewed laws and regulations related to the regulation of hospice agencies in California. • Reviewed Public Health's policies and procedures relevant to hospice licensing.
8	Evaluate the factors contributing to the prevalence of deemed-status hospice agencies in the State and, to the extent possible, analyze its impact on hospice quality, oversight, and transparency. Further, determine the number of third-party accreditation agencies operating in California and assess any potential differences in the accreditation process carried out by these third-party agencies compared to Public Health.	• Analyzed Public Health's hospice licensing data to determine the ratio of deemed hospice agencies to those that are not deemed. • Reviewed the contracts between Public Health and accreditors to identify the obligations of each. • Interviewed staff at Public Health to determine the information they collect from accreditors. • Compared the accreditors' hospice licensing standards with the State's standards. • Reviewed the number of complaints associated with deemed versus not deemed hospice agencies and reviewed CMS' data on quality of care.
9	Evaluate the effectiveness and comprehensiveness of Public Health's system to screen and license applicants for hospice licensure by doing the following: a. Determine whether Public Health considers geographic need, or lack thereof, for additional hospice agencies when issuing new hospice licenses and whether Public Health denies licenses due to lack of demonstrated need. b. Evaluate the factors Public Health considers when issuing hospice licenses, such as applicant experience, education, resources, and character, and whether Public Health ever denies applicants based on these criteria.	• Reviewed state law, hospice standards, and Public Health's policies and procedures relevant to hospice licensing, including whether they addressed geographic need. • Obtained Public Health's licensing data from 2010 through 2021, including the number of applicants approved and denied. • Evaluated the geographic distribution of hospice agencies across the State in order to identify large concentrations of agencies in specific areas. • Reviewed a judgmental selection of licensing files—five from Sacramento County and five from Los Angeles County—to determine compliance with state law and Public Health policies and procedures for licensing.

	AUDIT OBJECTIVE	METHOD
10	Evaluate the effectiveness of Public Health's inspection system for hospice agencies by doing the following: a. Determine the frequency of hospice agency inspections and repeated violations. b. Assess whether hospice agency inspections evaluate compliance with state and federal standards. c. Evaluate the sufficiency of California's hospice standards and potential improvements. d. To the extent possible, determine the potential effect inspections may have in deterring noncompliance.	• Reviewed state and federal laws and regulations relevant to hospice agency inspections. • Evaluated whether Public Health's hospice agency inspection policies and procedures are sufficient for ensuring compliance with state and federal requirements. • Reviewed Public Health's data on hospice agency inspections and frequent violations from 2015 through 2021. • Reviewed a judgmental selection of inspection files—five from Sacramento County and five from Los Angeles County—to determine compliance with Public Health's policies and procedures for inspections.
11	Determine the effectiveness of Public Health's system for identifying and investigating complaints against hospice agencies by doing the following: a. Assess Public Health's system for identifying, responding to, and prioritizing hospice complaints, the effectiveness of this system, and what improvements may be necessary. Identify the volume of annual complaints and whether any trends exist in their categorization. b. Determine whether Public Health has an effective process for informing hospice patients and their representatives about the complaint process and whether Public Health's process for communicating with complainants after a hospice investigation could be improved. c. Evaluate the timeliness of complaint investigations of hospice agencies, including how long complaints are open and how long investigations take, and identify whether a complaint backlog exists. d. Assess the adequacy and effectiveness of complaint investigations of hospice agencies and identify whether and how Public Health evaluates and measures their effectiveness. Determine the volume of complaints that are ultimately substantiated. e. Determine what enforcement actions are taken when complaints against a hospice agency are verified and whether these measures result in corrective actions. f. Determine whether Public Health has a process for determining complainant satisfaction with its complaint investigations and findings on hospice complaints and how the process could be more effective.	• Reviewed documentation of Public Health's complaint process, including ways it informs hospice patients and their families. • Evaluated Public Health's system for identifying and investigating complaints by judgmentally selecting and reviewing five complaint files from the Los Angeles district office and five complaint files from the Sacramento district office. • Reviewed records within each selected complaint file to determine Public Health's effectiveness in communicating with complainants. • Analyzed Public Health's data for hospice complaints from 2015 through 2020 to determine the timeliness of its investigations. Although we did not identify a backlog, we discuss in Chapter 2 our concerns with Public Health's timeframes for completing investigations. • Reviewed Public Health's investigation process, policies, and practices to determine their adequacy and effectiveness. • Reviewed federal and state law, regulations, and policies to determine existing enforcement sanctions. • Interviewed Public Health staff and determined that it does not have a process for assessing complainant satisfaction.
12	Evaluate the effectiveness of Public Health's system for enforcing hospice requirements by doing the following: a. Identify and describe the sanctions available to Public Health to enforce hospice requirements. b. Determine how often and under what circumstances Public Health applies sanctions to hospice agencies. c. To the extent possible, assess the effectiveness of Public Health sanctions against providers in deterring future violations, fraud, and abuse. d. Determine what reforms may be needed to strengthen enforcement of hospice requirements.	• Reviewed federal and state law and regulations related to hospice agency sanctions, as well as Public Health's relevant procedures. • Reviewed Public Health data on enforcement actions to determine how often and under what circumstances Public Health applies sanctions to hospice agencies. • Compared the sanctions Public Health can apply to hospice agencies to those it can apply to home health agencies to identify improvements to existing enforcement measures.

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	AUDIT OBJECTIVE	METHOD
13	Identify statutory reforms needed in California to provide regulators with the authority and resources to screen, discipline, deny, and revoke licensure for unqualified, unscrupulous, or unnecessary hospice agencies.	Through our work in the other objectives, identified recommendations for changes to state law and regulations.
14	Review and assess any other issues that are significant to the audit.	Reviewed Public Health's contract with the Los Angeles County Department of Public Health for licensing and certification services.

Source: Audit workpapers.

Assessment of Data Reliability

The U.S. Government Accountability Office, whose standards we are statutorily obligated to follow, requires us to assess the sufficiency and appropriateness of computer-processed information we use to support our findings, conclusions, and recommendations. In performing this audit, we relied on electronic data files that we obtained from Public Health, Health Care Services, DOJ, CMS, and the U.S. Census Bureau. To evaluate these data, we performed electronic testing of the data, reviewed existing information about the data, and interviewed state department officials knowledgeable about the data. We found the U.S. Census Bureau's data to be sufficiently reliable for the purpose of determining state and county populations. We found Public Health's data to be of undetermined reliability for the purposes of calculating the number of applications, licensed and deemed-status hospice agencies, the number of deaths among the aged population in Los Angeles County, and the number of complaints it had received. We found Health Care Services' Medi-Cal data to be sufficiently reliable for the purpose of calculating the amount of Medi-Cal fee-for-service spending on hospice services but of undetermined reliability for the purpose of analyzing hospice services, providers, and beneficiaries for possible indicators of fraud. We found DOJ's data to be of undetermined reliability for the purpose of calculating the number of complaint referrals it had received. We found CMS's Medicare data to be of undetermined reliability for the purposes of calculating the average duration of hospice services, average live discharge rates, and average amount paid per patient. Although we recognize that these limitations may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

ROB BONTA
Attorney General

State of California
DEPARTMENT OF JUSTICE

DIVISION OF MEDI-CAL FRAUD AND ELDER ABUSE
2329 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833-4252

Telephone: (916) 621-1858
Facsimile: (916) 263-0864

March 9, 2022

Michael Tilden, CPA
Acting California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

RE: Draft Audit Report 2021-123 – California Hospice Licensure and Oversight

Dear Mr. Tilden:

The Department of Justice (DOJ) appreciates the opportunity to provide comments to the above-mentioned draft audit report. Our copy of the draft report contains only the limited portions that refer directly to the DOJ. Accordingly, we respectfully offer the below comments which are limited to those unredacted excerpts.

DOJ's Division of Medi-Cal Fraud and Elder Abuse (DMFEA) serves as the State's Medicaid Fraud Control Unit. Per DMFEA's authority as a Medicaid Fraud Control Unit, DMFEA is responsible for the investigation and prosecution of fraud against the Medi-Cal system. As such, DMFEA is tasked with investigating and prosecuting fraud amongst all Medi-Cal provider types, of which hospice in one. DMFEA also investigates and prosecutes fraud committed by medical doctors, dentists, medical clinics, durable medical equipment suppliers, skilled nursing facilities, pharmacies, laboratories, in home supportive services providers, and numerous other provider types. Along with its other work, DMFEA also aggressively investigates referrals of hospice fraud, conducts data analysis to uncover hospice fraud, and prosecutes hospice companies who have defrauded the Medi-Cal program. Since 2015, DMFEA has investigated nearly 70 hospice related cases. Several of those investigations have resulted in convictions and several of the investigations are ongoing. As recently as February 16, 2022, DMFEA charged 16 individuals with fraud in relation to a hospice fraud scheme perpetrated throughout the Inland Empire.

We agree with the audit recommendations to address and improve State's ability to improve and investigate hospice care fraud discussed in this report.

The draft audit report notes DOJ did not pursue potential fraud providers, specifically, large clusters of hospice agencies located at certain addresses in Los Angeles County referred to DMFEA by the Department of Public Health (DPH). DMFEA does not have

any record of receiving this referral. Despite the lack of a referral, in November 2021, DMFEA actively participated with the U.S. Department of Health and Human Services – Office of the Inspector General (HHS-OIG) in "knock and talks"[1] at several hospice agencies in Van Nuys. The "knock and talks" were focused on hospice agencies located in buildings that housed numerous other hospice agencies. Although DMFEA did not receive the referral from DPH, as noted above, DMFEA has been very active in pursuing hospice fraud in Los Angeles County and recently charged 16 individuals with fraud in relation to a hospice fraud scheme perpetrated throughout the Inland Empire.

Recommendation to the Legislature
To address fraud that is likely occurring in Los Angeles County, the Legislature should require Public Health, Health Care Services, DOJ, and Social Services to immediately convene a taskforce to identify, investigate, and prosecute fraud and abuse by hospice agencies in that county. It should also require those four departments to establish a working group to annually meet to conduct a risk assessment of the Medi-Cal hospice program statewide, including performing analysis similar to those we conducted during this audit regarding growth in the number of hospice agencies, clustering of hospice agencies, and instances of medical personnel working at multiple hospice agencies. Because the fraud indicators we identified frequently also involved home health agencies, the four departments should also consider these risks as they relate to home health agencies. The four departments should adjust their fraud prevention and detection efforts based on the results of this assessment.

DOJ supports this recommendation and will work with the Legislature on it. DOJ frequently meets with the California Departments of Public Health (DPH) and Health Care Services (DHCS) to discuss fraud and abuse trends, referrals, and inter-agency cooperation.

DOJ will take part in a taskforce with the other State agencies listed to identify, investigate, and prosecute fraud and abuse by hospice agencies that receive Medi-Cal funding, commensurate with the clearly stated restrictions imposed on DMFEA by the federal grant which constitutes 75% of our operating budget.[2] DOJ will also be part of a working group to conduct a risk assessment of the Medi-Cal hospice program statewide, consistent with the same federal grant restrictions. Both the working group and the taskforce would be an addition to the work DOJ currently performs in-house with the use of data analytics. DOJ currently uses data analytics to look for outliers in Medi-Cal claims data from hospice providers. Many of the fraud indicators outlined in this report are currently used by DOJ to help identify potential fraud in the hospice program.

[1] A "knock and talk" is a technique used by law enforcement to gather intel, consensually, by knocking on someone's door and talking to the person of interest. This technique allows law enforcement to gather intel, ask questions, and observe what is in plain view.

[2] Medicaid Fraud Control Units must conduct a statewide program for investigating and prosecuting violations of all applicable state laws pertaining to fraud in the administration of the Medicaid program, the provisions of medical assistance, or the activities of [Medicaid] providers. See 42 CFR 1007.11(a). Medi-Cal is California's Medicaid program.

Michael Tilden, CPA
March 9, 2022
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Recommendation to DOJ
To improve its ability to investigate fraud and abuse, DOJ should provide guidance to Public Health about the types of information Public Health should include when it refers complaints that allege fraud to DOJ. Further DOJ should document a procedure for following up on complaints that do not include adequate information.

Leadership within DMFEA currently meets with DPH leadership twice a year to discuss fraud and abuse trends, referrals, and inter-agency cooperation. These meetings frequently include a discussion about the quality and quantity of referrals from DPH to DOJ, generally. DOJ has met with and provided training to DPH's District Managers regarding the information necessary to make quality referrals. In addition, DOJ staff are in frequent contact with DPH staff regarding referrals, on-going investigations, and coordinating operations. DOJ will continue to meet with DPH and provide training/guidance.

DMFEA and DPH are currently working to update their Memorandum of Understanding (MOU). The current MOU outlines the information necessary in a referral from DPH to DMFEA for multiple facility types, but does not specifically delineate hospice agencies. As part of the update, DOJ will seek to introduce terms outlining what is required specifically related to fraud related to hospice agencies and what a DPH referral related to hospice should contain. Additionally, the MOU currently sets forth a general procedure for acquiring additional information from DPH upon request by DOJ. This procedure is currently in practice. Per the MOU, DOJ staff frequently reaches out to the Centers for Medicare and Medicaid Services (CMS) to obtain authorization for DPH to provide DOJ with additional information regarding a referral. This usually occurs, however, only when there is sufficient information on the face of the referral to indicate fraud or abuse within DMFEA's jurisdiction.

If you have any questions or concerns regarding this matter, you may contact me at the telephone number listed above.

Sincerely,

JENNIFER EULER
Chief Assistant Attorney General
Division of Medi-Cal Fraud and Elder Abuse

For ROB BONTA
Attorney General

cc: Venus D. Johnson
Chief Deputy Attorney General

Chris Prasad, CPA
Director, Office of Program Oversight & Accountability

State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 10, 2022

Michael S. Tilden
Acting State Auditor
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

DRAFT AUDIT REPORT RESPONSE

Dear Mr. Tilden:

The Department of Health Care Services (DHCS) hereby submits the enclosed response to the California State Auditor (CSA) draft audit report number 2021-123 titled, “California Hospice Licensure and Oversight: The State’s Weak Oversight of Hospice Agencies Has Created the Opportunity for Large-Scale Fraud and Abuse.” DHCS appreciates the opportunity to respond to the report and provide our assessment of the CSA’s recommendation.

DHCS appreciates CSA acknowledging current data analytics and hospice fraud detection efforts currently being taken by DHCS via its use of a hospice profiler tool. The profiler tool is regularly updated to run algorithms to identify indicators of hospice fraud, waste and abuse that warrant investigation.

In the above audit report, CSA issued a recommendation for the Legislature. Notwithstanding our current efforts, DHCS agrees with CSA’s recommendation that the Legislature require collaboration among the California Department of Public Health, Department of Social Services and Department of Justice to conduct a more global risk assessment of the Medi-Cal hospice program statewide and to support increased efforts to identify, investigate and prosecute fraud and abuse by hospice agencies and providers.

Director’s Office
1501 Capitol Avenue, MS 0000
P.O. Box 997413, Sacramento, CA 95899-7413
Phone (916) 440-7400
Internet address: www.dhcs.ca.gov

Mr. Michael Tilden
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March 10, 2022

DHCS appreciates the work performed by the CSA and its perspective regarding increased opportunities to enhance hospice program integrity efforts. If you have any other questions, please contact Internal Audits at (916) 445-0759.
Sincerely,

Michelle Baass
Director

Enclosure

cc:

Jacey Cooper
State Medicaid Director
Chief Deputy Director
Health Care Programs
Department of Health Care Services
MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413
Jacey.Cooper@dhcs.ca.gov

Erika Sperbeck
Chief Deputy Director
Policy and Program Support
Department of Health Care Services
MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413
Erika.Sperbeck@dhcs.ca.gov

Bruce Lim
Deputy Director
Audits & Investigations
Department of Health Care Services
MS 2001
P.O. Box 997413
Sacramento, CA 95899-7413
Bruce.Lim@dhcs.ca.gov

Saralyn Ang-Olson
Chief Compliance Officer
Office of Compliance
Department of Health Care Services
MS 1900
P.O. Box 997413
Sacramento, CA 95899-7413
Saralyn.Ang-Olson@dhcs.ca.gov

Wendy Griffe, Chief
Internal Audits
Department of Health Care Services
MS 1900
P.O. Box 997413
Sacramento, CA 95899-7413
Wendy.Griffe@dhcs.ca.gov

Department of Health Care Services

Audit: California Hospice Licensure and Oversight: The State's Weak Oversight of Hospice Agencies Has Created the Opportunity for Large-Scale Fraud and Abuse

Audit Entity: California State Auditor
Report Number: 2021-123 (22-01)
Response Type: Draft Report Response

Finding 1: Numerous Indicators Suggest Large-Scale Hospice Fraud and Abuse in Los Angeles County. In addition, State Agencies have not adequately coordinated their fraud prevention efforts or developed meaningful enforcement measures.

Recommendation 1
To address fraud that is likely occurring in Los Angeles County, the Legislature should require the California Department of Public Health (CDPH), the California Department of Health Care Services (DHCS), the California Department of Justice (California DOJ), and the California Department of Social Services (CDSS) to immediately convene a taskforce to identify, investigate, and prosecute fraud and abuse by hospice agencies in that county. It should also require those four departments to establish a working group to annually meet to conduct risk assessment of the Medi-Cal hospice program statewide, including performing analyses similar to those we conducted during this audit regarding the growth in the number of hospice, clustering of hospice agencies, and instances of medical personnel working at multiple hospice agencies. Because the fraud indicators we identified frequently also involved home health agencies, the four departments should also consider these risks as they relate to home health agencies. The four departments should adjust their fraud prevention and detection efforts based on the results of this assessment.

Agreement: Agrees with Recommendation

Response:
While DHCS currently performs routine fraud analytics of hospice providers to identify investigative leads and conduct investigations when warranted, DHCS supports a more global risk assessment utilizing data and feedback from the CDPH, CDSS and California DOJ. As such, DHCS supports the formation of a task force, or working group, with the CDPH, CDSS, and California DOJ to assess fraud risks in the Medi-Cal Hospice Program. DHCS is committed to partnering with state agencies to implement this recommendation upon the Legislature chaptering legislation.

State of California—Health and Human Services Agency
California Department of Public Health

Tomás J. Aragón, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

March 11, 2022

Michael S. Tilden*
Acting California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Mr. Tilden:

The California Department of Public Health (Public Health) has reviewed the California State Auditor's (CSA) draft audit report titled, "California Hospice Licensure and Oversight: *The State's Weak Oversight of Hospice Agencies Has Created the Opportunity for Large-Scale Fraud and Abuse*." Public Health appreciates the opportunity to respond to the report and provide our assessment of the recommendations contained therein.

We are appreciative of the collaborative work between the CSA auditors and Public Health staff during this audit and we acknowledge that there are several opportunities for improvement in the oversight of hospice agencies. Public Health has already begun or will soon begin to operationalize several of the recommendations made in the audit in advance of regulations and/or legislative initiatives. These include shoring up referrals made to other State Departments where possible fraud may exist, training Public Health staff to better detect fraudulent activities, and adjusting our public website to improve reporting of ownership information for hospice agencies, among other things.

Many of the recommendations made in the audit require statutory changes and Public Health looks forward to providing technical assistance to Legislative members so that we have the authority to oversee and hold hospice providers accountable who may be providing substandard care or engaged in fraudulent activities. Additionally, to the extent that implementation of any of the recommendations result in a fiscal impact on hospice provider licensing fees, those costs and resource needs will be identified as part of the budget and legislative process.

The rapid growth of hospice providers and alleged fraud, as evidenced by the Department of Justice's recent arrests of several providers in San Bernardino, is cause for great concern and Public Health looks forward to discussions on how and under what circumstances to resume issuing new licenses.

California Department of Public Health / Director's Office
P.O. Box 997377 ● MS 0500 ● Sacramento, CA 95899-7377
(916) 558-1700 ● (916) 558-1762 FAX
www.cdph.ca.gov

* California State Auditor's comments begin on page 77.

Public Health will continue its efforts to develop regulations for hospice agencies and facilities and if the Legislature provides Public Health with authority to promulgate emergency regulations, we will transform our efforts to meet that mandate.

Below, we have numbered and provided responses to each of the recommendations included in the audit report.

1. To address fraud that is likely occurring in Los Angeles County, the Legislature should require Public Health, Health Care Services, DOJ, and Social Services to immediately convene a taskforce to identify, investigate, and prosecute fraud and abuse by hospice agencies in that county. It should also require those four departments to establish a working group to annually meet to conduct a risk assessment of the Medi-Cal hospice program statewide, including performing analyses similar to those we conducted during this audit regarding growth in the number of hospice agencies, clustering of hospice agencies, and instances of medical personnelworking at multiple hospice agencies. Because the fraud indicators we identified frequently also involved home health agencies, the four departments should also consider these risks as they relate to home health agencies. The four departments should adjust their fraud prevention and detection efforts based on the results of this assessment.

Response to Recommendation #1: Agree. Public Health agrees with this recommendation and is committed to working with Health Care Services, DOJ, and Social Services by convening an enforcement task force and establishing a risk assessment working group to meet annually.

2. The Legislature should require fraud training for any Public Health staff who are responsible for licensing and certification of hospice agencies, including training about the types of information that are necessary for making referrals to DOJ when they suspect fraud is occurring.

Response to Recommendation #2: Agree. Public Health can implement this recommendation administratively and plans to have the training in place by January 2023.

3. To help ensure that hospice owners and hospice management personnel are of good moral character, the Legislature should revise state law to require for each initial or renewal license application, that each hospice agency's owner, and its administrator, director of patient care services, administrator/director of patient care services designee, and medical director (hospice management personnel) submit electronic fingerprint images to DOJ for the furnishing of these individuals' criminal records to Public Health. The revision should also include a requirement that hospice agency owners and management personnel with certain criminal convictions, as determined by the Legislature, are prohibited from obtaining a license and are further prohibited from providing any hospice-

related service before obtaining either a criminal record clearance or a criminal record exemption from Public Health.

Response to Recommendation #3: Agree.

4. To protect against excessive and fraudulent growth in the number of hospice agencies, the Legislature should revise state law to require new, previously unlicensed hospice agencies to demonstrate an unmet need for hospice services in an area in which they wish to operate. The law should require that the number of hospice agencies in a given geographic region closely aligns with measures for the need for hospice services. It should also define appropriate measures of need and identify the methodology that hospice agencies must use to demonstrate need.

Response to Recommendation #4: Agree. Legislation would be necessary for Public Health to implement this recommendation.

5. To enable Public Health to better oversee the licensure of hospice agencies, the Legislature should require as a part of the licensure application financial information that is similar to the information required for home health agencies.

Response to Recommendation #5: Agree. Legislation would be necessary for Public Health to implement this recommendation. SB 664, Chapter 494, Statutes of 2021 imposed a temporary moratorium of this nature on new hospice providers. However, that statutory provision expires one year after the publishing of the auditor's report, expected to be in March 2023. An existing All Facility Letter prescribing the process new hospices must follow to demonstrate an unmet need for services is in effect but relies on the temporary statutory moratorium.

6. To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to issue emergency regulations within one year, while maintaining the general moratorium on new hospice licenses until Public Health issues the regulations. The emergency regulations should do the following:
    - Establish time and distance standards that define the maximum time and distance hospice agency staff may travel to reach patients, taking into consideration typical traffic conditions and whether the hospice agency is serving patients in rural or urban areas.

Response to Recommendation #6, bullet 1: Agree. Although Public Health does not have authority for emergency regulations, we will continue with the development of hospice regulations to strengthen oversight of hospice agencies.

- Establish guidelines for assessing the appropriateness of a hospice agency's ratio of patients to nurses.

Response to Recommendation #6, bullet 2: Agree.

- Establish a limit to the number of hospice agencies that hospice management personnel can be involved with concurrently.

Response to Recommendation #6, bullet 3: **Agree.**

- Require hospice management personnel to have hospice-specific training or experience.

① **Response to Recommendation #6, bullet 4: Agree.** May require legislation to establish a requirement that hospice management have specific training and experience.

- Require that, as part of its review of the initial application, Public Health verify that the hospice management personnel listed on the licensing application are, in fact, associated with the hospice agency, such as contacting them by phone, and verify the work history of hospice management personnel by speaking with these individuals' previous employers by phone.

Response to Recommendation #6, bullet 5: Partially Agree. The benefit of this verification process as recommended for determining eligibility to license an agency is not clear unless it is a condition for licensure. While Public Health agrees that affiliation of key members of the management team should be verified, requiring
② phone calls and reference checks of work history would result in a significant workload for the department. An alternate means of meeting the recommendation to validate affiliation should be considered.

- Require Public Health to verify the status of the professional licenses for all hospice medical personnel, including contracted medical directors, as part of an agency's initial application. The regulations should also establish guidelines for when Public Health must deny the application of a hospice agency that is proposing to use medical personnel whose professional license records indicate the imposition of a disciplinary action. For instance, probation for gross negligence or fraudulent billing should be a cause to deny a hospice agency's application, even if the medical director's license is currently active.

Michael S. Tilden
March 11, 2022
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Response to Recommendation #6, bullet 6: Agree. May require legislation to establish additional reasons for denying a hospice license. Currently, use of medical personnel who have had a disciplinary action against their license is not included in the grounds for denial of a hospice license. ①

- Establish requirements for conducting an initial licensing site visit that include verifying the identities of all hospice personnel and ensuring that the hospice agency is set up to provide adequate care. Public Health should develop specific requirements for hospice office space and verify compliance with those requirements during the initial site visit.

Response to Recommendation #6, bullet 7: Partially Agree. Public Health agrees that defining requirements for hospice office space is appropriate within regulations. We also agree with the policy to verify the identity and role of hospice personnel; however, the requirement and method for the state agency to do so is not appropriate for the regulatory process and instead should be imposed by statute. The department's authority for promulgating regulations is for the purpose of licensing health care providers, thus regulations are not the appropriate method for obligating the department to implement this recommendation. ①③

- Establish requirements for conducting follow-up inspections to the initial site visits within one year of initial licensing to verify that hospice agencies are complying with those hospice standards that cannot be assessed before the agencies begin providing care to patients. These inspections should be unannounced and take place after the hospice agency has begun caring for patients. During these inspections, Public Health should visit patients, ensure that the certifications of terminal illness are accurate, confirm that the hospice agency is providing adequate care, check hospice personnel identities and medical licenses, and ensure that the hospice agency has reported any personnel changes.

Response to Recommendation #6, bullet 8: Partially Agree. State agencies are subject to mandates that are set forth in state law through the legislative process. Regulations are meant to clarify or make specific requirements based on those laws. If the department were to adopt regulations in this manner, the state agency would be tasked with regulating itself. The department's authority for promulgating regulations is for the purpose of licensing health care providers; thus, regulations are not the appropriate method for implementing this recommendation. The department's existing process for inspecting hospices or investigating complaints already includes requirements for those visits to occur unannounced. Once the surveyor initiates the inspection at the hospice agency, one or more patients are selected by the surveyor and permission to visit the patient's home is requested. It ④

should also be noted that certification of a terminal illness is completed by a physician and this would be outside of the scope of practice of our nurse surveyors.

7. To ensure that all licensed hospice agencies comply with Public Health's newly adopted regulations, the Legislature should revise state law to require Public Health to conduct a license renewal for all currently licensed hospice agencies within two years after the regulations are adopted. It should also revise state law to require Public Health to perform license renewal inspections for all licensed hospice agencies periodically. If it performs them every 18 months, every other cycle will coincide with Medicare recertification inspections, which are required at least every 36 months.

Response to Recommendation #7: Partially Agree. Given the significant number of licensed hospice providers, Public Health would require a multi-year phased approach to conduct these licensing surveys that would span more than two years.

8. To increase oversight of deemed status hospice agencies, the Legislature should amend state law to require Public Health to do the following:

    - Collect and monitor full survey reports from accreditors for all deemed status hospice agencies.

⑤ **Response to Recommendation #8, bullet 1: Disagree.** This recommendation cannot be implemented by Public Health. The Centers for Medicare and Medicaid Services (CMS) contract directly with approved Accredited Organizations (AO) to conduct certification surveys for deemed providers who participate in the Medicare program. The contract between CMS and the AOs does not provide access to the certification surveys by state agencies.

    - Annually audit a selection of at least 5 percent of deemed status hospice agencies and monitor these agencies to ensure that they take any necessary corrective actions.

Response to Recommendation #8, bullet 2: Agree.

9. The Legislature should revise state law to include a system of sanctions for Public Health to levy, including fines or license revocation for the following:

    - Violations of state law, regulations, or hospice standards by a hospice agency, including improperly certifying a patient as eligible for hospice care.

- Failure by hospice management personnel to be present for an inspection or complaint investigation.

- Failure by a hospice agency to report a change in owner, hospice management personnel, or location.

Response to Recommendation #9, all 3 bullets: Agree. Legislation would be required for Public Health to implement these recommendations.

10. To ensure that Public Health appropriately addresses the complaints it receives, the Legislature should require it to do the following:

    - Establish timeframes within which Public Health must initiate and complete its investigation of hospice complaints.

Response to Recommendation #10, bullet 1: Agree.

- Develop a comprehensive training manual regarding performing investigations. The manual should include specific guidance for interviewing witnesses, collecting, and reviewing documentation, and following up on discrepancies to properly and thoroughly address complaints.

Response to Recommendation #10, bullet 2: Agree. Public Health already has a policy and procedure manual outlining the complaint investigation process and we will administratively reassess this policy considering the recommendations of this audit.

11. To help ensure that residents of long-term care facilities are not taken advantage of by unscrupulous hospice agencies, the Legislature should require Public Health and Social Services to develop materials to educate current and future residents of these facilities and their families about common hospice fraud schemes, including efforts to mislead residents to sign up for hospice care. It should also require Public Health to include this information on its website.

Response to Recommendation #11: Agree. Public Health will work collaboratively with Social Services to implement this recommendation.

12. To ensure that the public has adequate information when selecting a hospice agency to provide care, the Legislature should require Public Health to revise its Cal Health Find website by October 2022 to include the following:

- Up-to-date information about the ownership and license status for each hospice agency licensed by Public Health.

Response to Recommendation #12, bullet 1: Agree. Cal Health Find can be modified by Fall 2022; however, Public Health would require more time to collect and validate hospice ownership information given the significant number of licensed providers.

- Specific identifiers to differentiate between complaints that were unsubstantiated based on a review of sufficient evidence and complaints that were unsubstantiated because Public Health could not reach a conclusion due to lack of evidence.

⑥ **Response to Recommendation #12, bullet 2: Disagree.** This recommendation will create confusion for the public and creates an overlapping distinction for our existing category of substantiated without regulatory violation and unsubstantiated. This also would create a discrepancy in the terminology used to report investigative outcomes between the state and federal processes.

- A quality of care rating system for hospice agencies similar to the one that Medicare uses for Care Compare. After all hospice agencies have been inspected based on the new regulations, Public Health should begin reporting the quality of care ratings.

Response to Recommendation #12, bullet 3: Partially Agree. CMS intends to develop a Consumer Assessment of Health Care Provider System (CHAPS) star rating for hospice providers by August 2022. Public Health's Cal Health Find Website displays the CMS star ratings for facilities that have them. Once the federal CHAPS system is available, Cal Health Find will be updated to include this
⑦ information for hospices. Implementation of this recommendation would be redundant and could be contradictory to information ultimately displayed on CMS' dashboard.

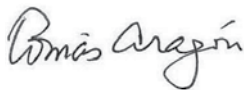
- An indicator or icon identifying individuals involved with a hospice agency who have received citations for abuse or neglect in the past year.

⑧ **Response to Recommendation #12, bullet 4: Partially Disagree.** Public Health does not cite individuals. Public Health enforcement actions are levied against the licensed hospice agency. We do not disagree with the concept of abuse indicators; however, legislation would be required to authorize Public Health to publicly display the information following the exhaustion of appeal rights.

Michael S. Tilden
March 11, 2022
Page 9

We appreciate the opportunity to respond to the audit. If you have any questions, please contact Mónica Vázquez, Deputy Director, Office of Compliance, at (916) 306-2251.

Sincerely,



Tomás J. Aragón, M.D., Dr.P.H.
Director and State Public Health Officer

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

To provide clarity and perspective, we are commenting on the response to our audit from Public Health. The numbers below correspond to the numbers we have placed in the margin of the response.

We disagree with Public Health's statement that implementing this recommendation may require legislation. The Licensure Act gives Public Health the authority to establish rules and regulations as may be necessary or proper to exercise its powers and perform its licensure duties. As we state on page 33, Public Health has had the authority to issue regulations since 1991 but has failed to do so. Moreover, we believe the standard rulemaking timeline is too long to allow the significant and serious risks to the health and safety of hospice patients we have identified to continue. Consequently, we recommended that the Legislature require Public Health to issue emergency regulations in part to address these risks. ①

We believe that contacting the most recent employer listed in the employment history would not result in an unreasonable workload. As we describe on page 19, there is currently a general moratorium on licensing new hospice agencies. Further, we recommend on page 50 that the Legislature require any new, previously unlicensed hospices to demonstrate an unmet need for hospice services in the area where they desire to operate, which will likely limit the number of applications Public Health receives and would need to verify work histories. Moreover, we believe such verification is crucial to ascertaining the qualifications of hospice management personnel who have significant responsibility for the health and safety of vulnerable patients. ②

Public Health misunderstands our recommendation. The recommendation is for the Legislature to require Public Health to establish requirements that hospice agencies will have to comply with to qualify for licensure. As we state on page 31, Public Health's efforts to verify information that it receives are minimal, leading to a failure to adequately screen applicants. Moreover, on page 26 we express concerns that many individuals listed as hospice agency administrators may have had their identities stolen by hospice agencies to fraudulently obtain licenses. ③

Public Health misconstrues our recommendation. The recommendation would not result in Public Health regulating itself, but rather would direct Public Health to establish requirements ④

for hospice agencies to comply with to qualify for licensure. As we explain starting on page 5, the licensing process consists of an application and an initial site visit. However, as we point out on page 35, some of the hospice standards cannot be verified prior to the hospice agency being licensed and operating. This recommendation would require Public Health to establish a follow-up inspection to the initial site visit to verify the hospice agency's compliance with those standards that cannot be assessed before it begins to provide care to patients.

(5) We disagree with Public Health's statement that it cannot implement the recommendation to collect and monitor full reports from accreditors. The Licensure Act expressly requires accreditors to forward to Public Health copies of all accreditation reports or findings for hospice agencies that it licenses based on accreditation. In addition, the contracts between Public Health and the accreditors require the accreditors to provide copies of inspection reports to Public Health. Accordingly, we believe that Public Health has sufficient authority to obtain these documents. Nevertheless, as we state on page 38, Public Health has not enforced this requirement. Additionally, recent changes to federal law make the accreditors' reports public as of October 2022, as we note on page 39, so Public Health's concerns are likely moot moving forward.

(6) Contrary to Public Health's response, our recommendation would provide clarity to the public regarding the categorization of complaints. As we describe on page 40, Public Health may identify an allegation as unsubstantiated for two distinct reasons: it concludes that the alleged action did not occur based on the evidence, or there is lack of sufficient evidence to reach a conclusion. We believe that it is important to clearly differentiate between these two very different outcomes. The terminology that Public Health uses for its other reporting requirements should not preclude it from categorizing complaints in a manner that would provide meaningful information to the public when selecting a hospice agency.

(7) We stand by our recommendation. Although CMS intends to report ratings based on consumer surveys, such reports would apply only to those hospice agencies certified by CMS, rather than all hospice agencies in the State. Therefore, we believe that it is important for Public Health to develop and report quality-of-care ratings for all hospice agencies it licenses. That effort can encompass leveraging ratings that CMS reports for hospice agencies it certifies.

(8) We revised the text on page 53 to clarify that the recommendation is focused on identifying hospice agencies that have received citations.

CDSS
KIM JOHNSON
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

GAVIN NEWSOM
GOVERNOR

March 8, 2022

Michael S. Tilden, CPA*
Acting California State Auditor
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

SUBJECT: RESPONSE TO CALIFORNIA STATE AUDITOR'S REPORT 2021-123

Dear Mr. Tilden:

Below you will find the California Department of Social Services (CDSS) response to the recommendations for CDSS in the California State Auditor's (CSA) Draft Report 2021-123 titled "California Hospice Licensure and Oversight: The State's Weak Oversight of Hospice Agencies Has Created the Opportunity for Large-Scale Fraud and Abuse."

CSA Recommendation #1:

Recommendation to the Legislature: *To address fraud that is likely occurring in Los Angeles County, the Legislature should require Public Health, Health Care Services, DOJ, and Social Services to immediately convene a taskforce to identify, investigate, and prosecute fraud and abuse by hospice agencies in that county. It should also require those four departments to establish a working group to annually meet to conduct a risk assessment of the Medi-Cal hospice program statewide, including performing analyses similar to those we conducted during this audit regarding growth in the number of hospice agencies, clustering of hospice agencies, and instances of medical personnel working at multiple hospice agencies… The four departments should adjust their fraud prevention and detection efforts based on the results of this assessment.*

CDSS Response:

CDSS remains steadfast in its efforts to protect the health and safety of residents in licensed Adult and Senior Care facilities. CDSS agrees with this recommendation , which includes convening an enforcement task force and establishing a risk assessment working group to meet annually. In doing so, CDSS will continue working collaboratively with sister agencies and a broad spectrum of stakeholders that includes

* California State Auditor's comments appear on page 81.

advocates, providers, licensees, and others. CDSS commits to partnering with state agencies to implement this recommendation upon the Legislature chaptering legislation.

CSA Recommendation for CDSS:

Recommendation to the Legislature: To help ensure that residents of long-term care facilities are not taken advantage of by unscrupulous hospice agencies, the Legislature should require Public Health and Social Services to develop materials to educate current and future residents of these facilities and their families about common hospice fraud schemes, including efforts to mislead residents to sign up for hospice care.

CDSS Response:

CDSS agrees with this recommendation, which addresses the development of consumer protection materials to educate current and future residents of facilities and their families in regard to signing up for hospice care. In doing so, CDSS will continue working collaboratively with sister agencies and a broad spectrum of stakeholders that includes advocates, providers, licensees, and others. CDSS commits to partnering with CDPH to implement this recommendation upon the Legislature chaptering legislation. However, developing materials may incur additional costs.

① Finally, CDSS would like to add that while reviewing the audit findings on page 51 (pg. 66 in the pdf), there is a paragraph that includes the line: "CDSS does not identify or analyze complaints against hospice agencies that involve residents of long-term care facilities." CDSS would like to clarify that the Department does take those complaints, investigate, and cross-report them to DPH and DOJ. However, they are not identified as hospice complaints since CDSS does not license hospice care; instead, the complaints are identified as personal rights or care and supervision violations. CDSS

② proposes the following amendment to this paragraph: "Currently, Public Health and Social Services do not identify or analyze complaints ***of fraud*** against hospice agencies that involve residents of long-term care facilities."

RESPONSE FOLLOW UP

Questions or requests for clarification regarding the information in this letter should be directed to Debbie Richardson, Chief, Office of Audit Services at Debbie.Richardson@dss.ca.gov.

In partnership,

KIM JOHNSON
Director

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

To provide clarity and perspective, we are commenting on the response to our audit from Social Services. The numbers below correspond to the numbers we have placed in the margin of the response.

During the publication process for the audit report, some page numbers shifted. The text that Social Services cites in its response is on page 45 of our report. ①

We stand by the text in our report stating that Social Services does not currently identify or analyze complaints against hospice agencies that involve residents of long-term care facilities. We did not revise this text as Social Services suggests because we determined that Social Services does not identify or analyze hospice complaints, fraud-related or otherwise. As we indicate starting on page 44, we analyzed hospice complaints and found many that allege hospice agencies had targeted residents of long-term care facilities to become hospice patients, sometimes through fraudulent means. Accordingly, we believe that Social Services needs to notify its residents of this risk, as we state on page 45. ②